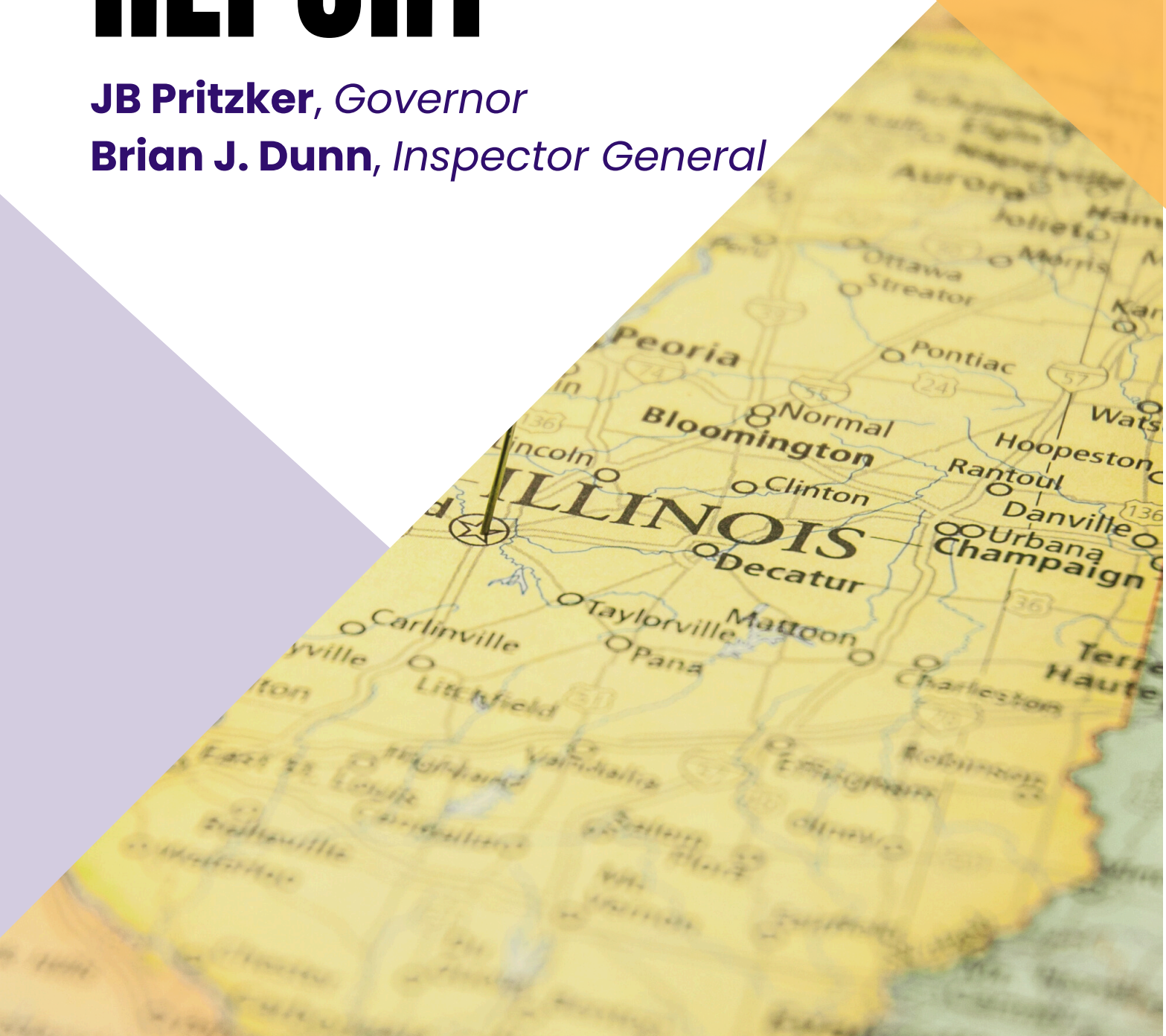
State of Illinois
Department of Healthcare & Family Services
Office of Inspector General

FY2024 ANNUAL REPORT

JB Pritzker, *Governor*
Brian J. Dunn, *Inspector General*



MESSAGE FROM THE INSPECTOR GENERAL

To Governor Pritzker, Senators, Representatives, and Residents of Illinois:

I am pleased to present the Fiscal Year 2024 annual report for the Office of Inspector General for the Illinois Department of Healthcare and Family Services (OIG).

This year begins the 30-year anniversary of the OIG. Milestones like these offer an opportunity to reflect on both the originating mission of this organization and the progress that we have made over the years. In OIG's first report, it noted the office "must play a larger role in the identification and implementation of systematic strategies aimed at prevention first. The most important responsibility of the Inspector General will be to work with the Department to identify major areas of improvement, initially focusing on the Medical Assistance Program, to prevent inappropriate expenditures."[1] Thirty years later, this report illustrates that commitment to the prevention of fraud, waste, and abuse through a number of initiatives, including:

- Excluding sanctioned individuals from becoming Medicaid providers to avoid future issues;
- Creating a Chief Managed Care Program Integrity Officer to strengthen communication and oversight with Medicaid Managed Care Organizations;
- Using data to enhance monitoring of customers' overlapping eligibility in other states and prescribing concerns that require further review; and
- Building platforms to increase awareness of OIG's oversight activities to deter bad actors.

This focus on improvement and prevention will continue to guide our work during our anniversary year and in the years to come.

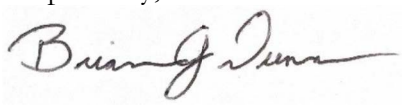
That same report from 30 years ago also acknowledged the sad fact that "it is a given that a few clients, providers, and employees will act inappropriately no matter how well the fraud control system is designed. The OIG will continue to vigorously conduct individual investigations, reviews and audits to identify overpayments, misconduct and quality of care issues."[2] This year's annual report illustrates our expanding success in these areas, as recent operational changes continue to pay dividends. Examples include:

- In FY2024, OIG identified over $66 million in questioned costs and achieved over $133 million in cost avoidance – $58 million and $96 million more than last year, respectively;
- Our Bureau of Investigations referred 57 cases to the Medicaid Fraud Control Unit for criminal investigation – 40 more than in FY2023; and
- OIG's Audit Section established over $36 million in overpayments through internal and external audits, which was 4.5 times last year's overpayment value.

[1] Report to the Governor, December 1994, Office of Inspector General, Illinois Department of Public Aid, p.1
[2] *Id.* at p.2.

Through our continued rigorous program integrity efforts, OIG will continue to both detect and deter fraud, waste, and abuse in Illinois' most essential benefit programs.

Respectfully,



Brian J. Dunn
Inspector General

IMPORTANT LINKS

Website – https://hfs.illinois.gov/oig/welcome.html
Complaint Portals – https://hfs.illinois.gov/oig/reportfraud.html
Exclusion List – https://ilhfspartner3.dynamics365portals.us/sanctions/

TABLE OF CONTENTS

SELECTED ABBREVIATIONS AND ACRONYMS

Bureau of Fraud Science and Technology	BFST
Bureau of Internal Affairs	BIA
Bureau of Investigations	BOI
Bureau of Medicaid Integrity	BMI
Centers for Medicare and Medicaid Services	CMS
corporate integrity agreement	CIA
Dynamic Network Analysis	DNA
fraud, waste, and abuse	FWA
fee-for-service	FFS
Healthcare Fraud Prevention Partnership	HFPP
Illinois Department on Aging	IDoA
Illinois Department of Financial and Professional Regulation	IDFPR
Illinois Department of Healthcare and Family Services	HFS
Illinois Department of Human Services	DHS
Long-Term Care Asset Discovery Initiative	LTC-ADI
managed care organization	MCO
Medicaid Fraud Control Unit	MFCU
Medical Quality Review Committee	MQRC
New Provider Verification	NPV
Office of the Illinois Attorney General	OAG
Office of Counsel to the Inspector General	OCIG
Office of Inspector General	OIG
Payment Error Rate Measurement	PERM
Provider Analysis Unit	PAU
public health emergency	PHE
Recipient Analysis Unit	RAU
Recovery Audit Contractor	RAC
Unified Program Integrity Contractor	UPIC
U.S. Department of Health and Human Services	HHS

Activities and Impact in FY2024

FY2024 SIGNIFICANT ACTIVITIES

FY2024 FINANCIAL IMPACT

Dollars Recovered are *overpayments that have been collected* based on the results of an investigation, audit, inspection, or review. Dollars Recovered would first have been calculated as overpayments identified in Questions Costs, either from this fiscal year or a prior fiscal year.

Provider Audits:	$8,760,380
Global Settlements:	$261,443
Spousal Support:	$248,205
Restitution:	$29,909
Total:	**$9,299,937**

Questioned Costs are *overpayments identified for recovery* during an OIG investigation, audit, or review due to an alleged violation of a statute, law, regulation, rule, policy, or other authority governing the expenditure of funds.

Provider Audits:	$36,716,759
Provider Investigations:	$26,418,144
Client Overpayments:	$2,011,014
Spousal Support Orders:	$1,056,510
Restitution:	$252,332
Total:	**$66,454,759**

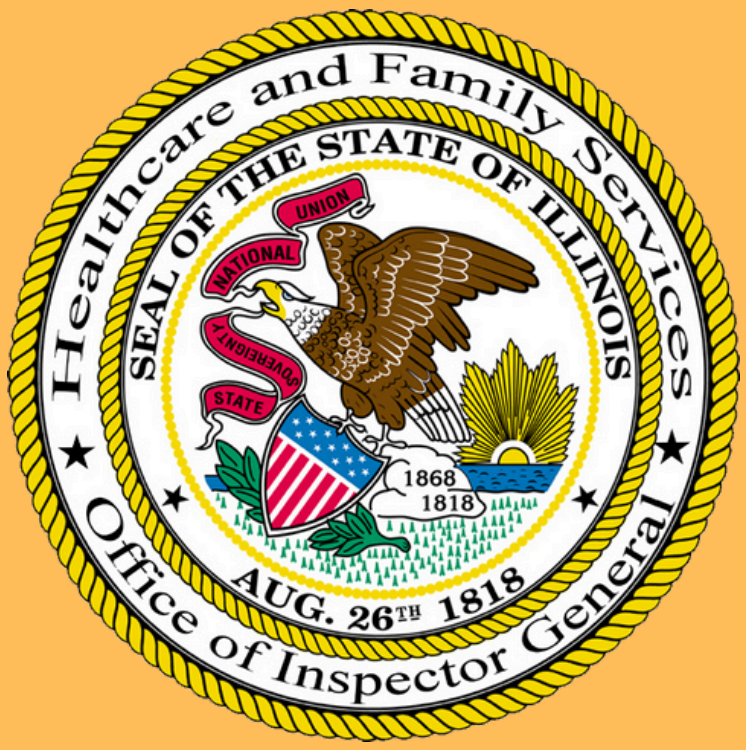
Cost Avoidance represents *funds which were not expended* after identifying that the operational, medical, contract, or grant expense was unnecessary.

LTC-ADI:	$104,722,734
Recipient Restriction Program:	$18,097,659
Provider Sanctions:	$8,301,288
Residency Verifications:	$1,893,071
Total:	**$133,014,752**

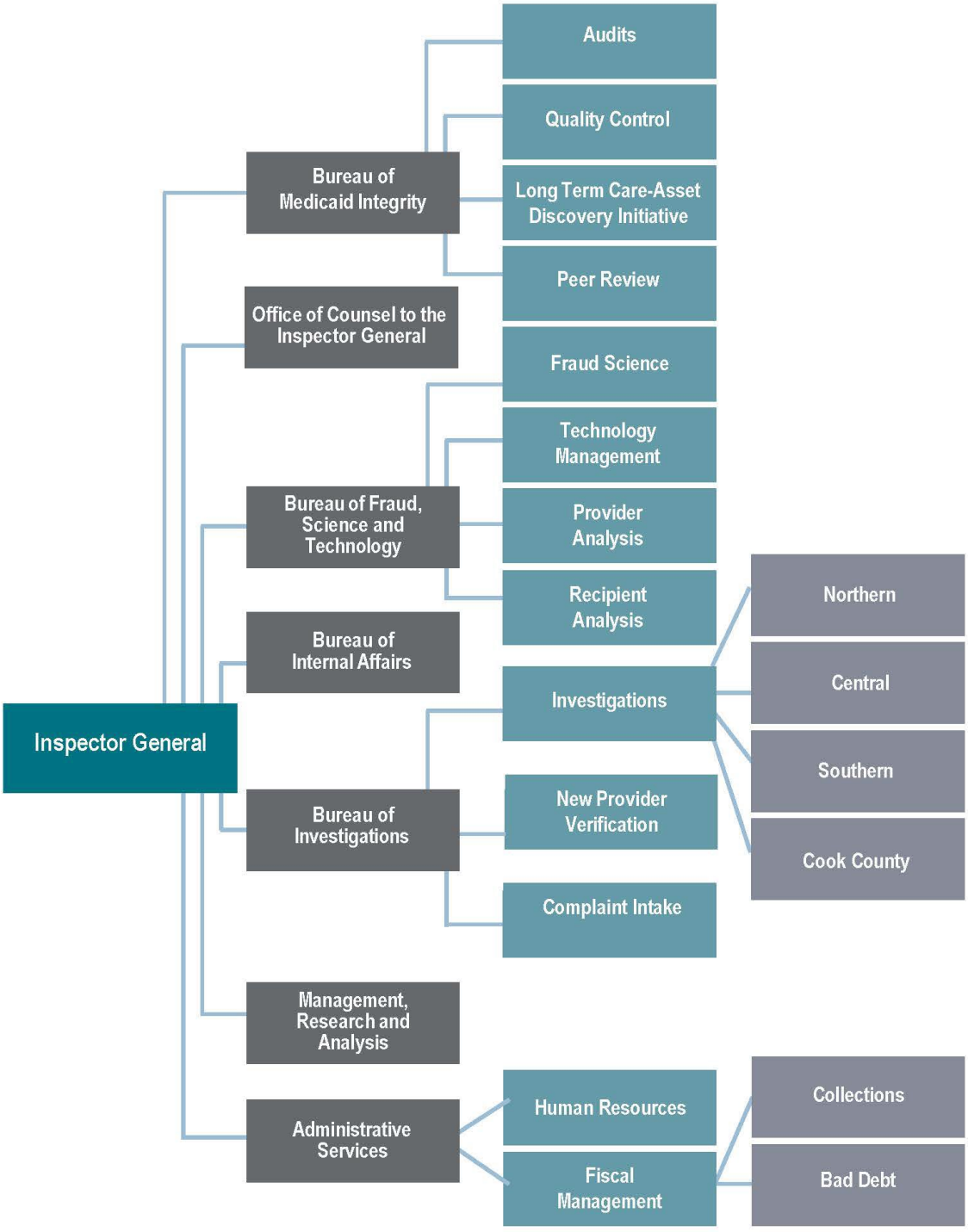
MCO Overpayments and Recoveries are *overpayments that the managed care organizations' special investigation units identified* were paid to network providers as the result of fraud, waste, or abuse. OIG reviews these findings and approves the overpayments for collection, if appropriate. Currently, under their contracts with HFS, the MCOs retain these monetary recoveries.

MCO Overpayments Approved for Recovery:	$23,041,619
MCO Overpayments Recovered:	$1,260,520

About the HFS OIG



ORGANIZATION AND STRUCTURE



OIG MISSION AND AUTHORITY

Mission

The mission of the HFS OIG is to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct in the Illinois Medicaid program.

Jurisdiction, Powers, and Authority

Under HFS OIG's enabling statute, 305 ILCS 5/12-13.1 *et seq.*, HFS OIG is charged with oversight of the programs of the Illinois Department of Healthcare and Family Services, including the Illinois Medicaid program; the Illinois Department on Aging's programs; and certain programs of the Illinois Department of Human Services, as established by agreement.

HFS OIG is empowered to:

- Investigate misconduct by employees, vendors, contractors, and medical providers.
- Perform prepayment and post-payment audits on Medicaid providers.
- Monitor quality assurance programs.
- Measure quality control of programs.
- Investigate fraud or intentional program violations.
- Initiate actions against contractors, vendors, or medical providers for program violations, issue sanctions against providers, recover assessments against hospitals and long-term care facilities, and for contract violations.

HFS OIG has the authority to:

- Access information necessary to perform its duties.
- Share data with other state and federal agencies.
- Deny and suspend payments to providers and vendors.
- Deny, suspend, or terminate a provider's enrollment in the Illinois Medicaid program.
- Serve as the Illinois Medicaid program's primary liaison with law enforcement.
- Subpoena the attendance and testimony of witnesses and the production of records.

OIG LEADERSHIP TEAM

Brian Dunn - Inspector General

Brian joined OIG in April 2021 after having served for six years as the First Deputy Inspector General and General Counsel for the City of Chicago Office of Inspector General. Prior to that, Brian was General Counsel for the Illinois Department of Human Services and the Illinois Department of Commerce and Economic Opportunity, and an Associate General Counsel for the Office of the Governor of Illinois. Before joining public service, Brian worked as a litigation associate for Mayer Brown LLP and clerked for the Honorable James Moran of the United States District Court for the Northern District of Illinois. Brian is a Certified Inspector General with the Association of Inspectors General.

Stephanie A. Snow - Chief of Staff

Stephanie joined OIG in November 2022 as the Office's first Chief of Staff after having served as Chief Assistant Inspector General for the City of Chicago's Office of Inspector General. After graduating from the University of Illinois at Chicago School of Law, Stephanie served as a law clerk and staff attorney for several federal courts, including the U.S. District Court for the Eastern District of Wisconsin (the Honorable Nancy Joseph), the U.S. District Court for the Northern District of Illinois (the Honorable Sharon Johnson Coleman), and the U.S. Court of Appeals for the Eighth Circuit. Stephanie joined the City of Chicago Office of Inspector General in 2020 as an Assistant Inspector General and was later promoted to Chief AIG, where she counseled staff on all aspects of their work, including investigations, program audits, reviews, and inquiries. Stephanie is a Certified Inspector General Investigator with the Association of Inspectors General.

Anthony Florio - Deputy Inspector General for Investigations

Tony joined OIG in March 2022 as the Deputy Inspector General for Investigations after having worked in the City of Chicago's Office of Inspector General for seventeen years. Over that time, Tony worked his way from an Investigator I to a Chief Investigator, leading a team in complex investigations involving comprehensive data analysis, surveillance, extensive interviewing, and high-profile criminal and administrative allegations. Tony is a licensed attorney, and is also a Certified Inspector General and a Certified Inspector General Investigator with the Association of Inspectors General.

Nathan Kipp - Chief Legal Counsel

Nathan joined OIG in February 2022 after having served nearly half of a decade in offices of inspectors general for City of Chicago sister agencies: first, as an Assistant Inspector General for the Chicago Board of Education, and then as both the Deputy Inspector General and Interim Inspector General for the Chicago Park District. A seasoned litigator, Nathan previously practiced law as a member of the global litigation groups within Mayer Brown LLP and Winston & Strawn LLP, where he handled complex and class-action lawsuits. Before entering private practice, he served as a staff attorney for the U.S. Court of Appeals for the Seventh Circuit before transitioning to the role of a judicial clerk for the Honorable

Michael S. Kanne. Nathan is a Certified Inspector General with the Association of Inspectors General.

Isela C Arellano – Chief Managed Care Program Integrity Officer
Isela initially joined OIG in February 2018 as Counsel to the Inspector General. Before working for the OIG, Isela served as an Administrative Appeals Hearing Officer for the Departments of Healthcare and Family Services and Human Services. Isela has a long history in public interest law, having worked as an associate for a Wisconsin-based firm, championing the legal rights of workers, families, and labor unions prior to her time in public service. A graduate of the University of Wisconsin Law School, Isela is licensed to practice law in Wisconsin and Illinois. She is a Certified Inspector General Auditor with the Association of Inspectors General, and a Certified Coder with the American Association of Professional Coders.

Lisa Castillo - Bureau Chief, Bureau of Medicaid Integrity
Lisa oversees the daily operations of four distinct Medicaid compliance units in OIG consisting of Audits, Peer Review, Quality Control, and Long-Term Care Asset Discovery. Lisa also manages a breadth of complex external Medicaid audits including the UPIC and the RAC. Before becoming Bureau Chief, Lisa served in the OIG's Office of Counsel to the Inspector General where she litigated administrative actions for recovery and terminations. Lisa has also served as an HFS Administrative Law Judge and a Cook County Assistant State's Attorney. Lisa earned her JD from the University of Illinois at Chicago and her Bachelor of Science from DePaul University. She obtained credentialing from the American Association of Professional Coders as a Certified Medical Coder and Certified Professional Medical Auditor. Lisa is a Certified Inspector General Auditor with the Association of Inspectors General.

Brian J. Bond - Chief, Bureau of Investigations
Brian has been with OIG since September 2012. He assumed his current role as Bureau Chief in October 2022 after acting into the position, while continuing to serve as the Supervisor of the Southern Unit for Investigations. Brian has been with HFS since October 1998, serving in various capacities including as the Department's State Purchasing Officer and in several leadership positions within the Department's Finance division. Brian is a Certified Inspector General Investigator with the Association of Inspectors General.

Wei-Shin Wang - Bureau Chief, Bureau of Fraud Science and Technology
Wei-Shin has worked in state government for thirty years. Prior to starting at OIG in 2007, he served as a Project Director and developed a statewide Medicaid initiative tracking mental health fee-for-service and grant-in-aid providers. From 2007 to 2011, Wei-Shin also served as the Project Manager and Acting Project Director for the Centers for Medicare and Medicaid Services Medicaid Transformation Grant. During that time, Wei-Shin successfully led a team to establish the comprehensive, online Dynamic Network Analysis system to monitor the services and payments for the state's Medicaid providers and recipients.

Steve Bandy - Assistant Bureau Chief, Bureau of Fraud Science and Technology
Steve started with HFS in 1987. For the past five years he has served in OIG's Bureau of Fraud Science and Technology as operational and analytical support to the office. Before joining OIG, he served as analytical support for the implementation of Medicaid's provider enrollment system, IMPACT; managed programs focused on provider reimbursement, unpaid bills, and eligibility issues; started a new unit to provide electronic claim transaction support; was a budget support analyst; and analyzed access to care across the state. Steve also provided SQL and NOMAD programming and support for the Enterprise Data Warehouse and the older mainframe, respectively. While serving with the U.S. Air Force, Steve graduated from Southern Illinois University with Bachelor of Science in Industrial Technology and completed an associate degree in Radio Communications.

Melissa Block - Section Manager, Management, Research and Analysis
Missy joined OIG in November 2013, continuing her career in state government. Prior to OIG, Missy spent over five years with HFS' Provider Enrollment Services, and two years at the Illinois Department of Financial and Professional Regulation. Missy graduated from Illinois College with a Bachelor of Arts in Economics/Business Administration and Fine Art and began her state service as a Graduate Public Service Intern for the University of Illinois at Springfield, working as a Recycling and Energy Educator for the Illinois Department of Commerce and Economic Opportunity from 2000-2004. Missy is a Certified Inspector General Inspector/Evaluator with the Association of Inspectors General.

Marsha Eiter - Fiscal Manager
Marsha joined OIG in February 2013 as the Assistant Bureau Chief of the Bureau of Fraud Science and Technology. Marsha later transitioned to the Bureau of Medicaid Integrity as Audit Manager and then as Assistant Bureau Chief overseeing the Audit and Peer Review Units. Subsequently, Marsha transferred to her current position as Fiscal Manager. Marsha joined the Illinois Department of Public Aid, later HFS, as a budget analyst in 1988. Marsha left state service in 2007 and worked as an information technology consultant with the Illinois Department on Aging and OIG for three years. She worked for United Healthcare as a Senior SAS Programmer and UNIX administrator for three years before joining OIG.

Kimberly Herrington - Human Resources/Labor Relations Liaison
Kimberly joined OIG in September 2019, having previously worked at DHS's Bureau of Recruitment and Selection for fourteen years. Prior to that, she worked in DHS's Human Resources since 1997. Kimberly assists and offers advice to OIG staff related to human resources and labor relations.

OIG'S EXTERNAL PARTNERS

State

Medicaid Fraud Control Unit (MFCU) - Under federal law, states are required to operate a MFCU, which is tasked with investigating and prosecuting Medicaid provider fraud and abuse or neglect of residents in healthcare facilities. Illinois's MFCU is operated by the Office of the Illinois Attorney General. HFS OIG is statutorily mandated to report suspected Medicaid provider fraud to MFCU. HFS OIG and MFCU collaborate on active investigations and prosecutions of Medicaid providers, gathering information and data, identifying subject matter experts on policy and programs, and providing witness testimony in criminal and civil proceedings. HFS OIG and MFCU work together through both formal and informal communication to ensure that both administrative and criminal proceedings advance without conflict.

Illinois Department of Financial and Professional Responsibility (IDFPR) – Many providers enrolled in the Medicaid program work in professions licensed and regulated by IDFPR. To maintain Medicaid enrollment, providers must hold all required professional licenses in good standing. The suspension or termination of a professional license will result in HFS OIG pursuing a provider's termination from Medicaid. Due to the overlap in HFS OIG's oversight and IDFPR's regulatory jurisdiction, these entities work closely to ensure that their efforts are coordinated, and that each agency is aware of actions against common providers. HFS OIG and IDFPR share information through referrals, document requests, data sharing, and monthly meetings.

Illinois Department of Human Services (DHS) and Illinois Department on Aging (IDoA) – DHS and IDoA have been delegated the day-to-day operations for certain Illinois Medicaid waiver programs. Under this delegation, these agencies often receive information regarding potential fraud, waste, and abuse in their waiver programs. DHS and IDoA also maintain expertise on their waiver policies, their network of providers, and their client population. HFS OIG works closely with these agencies and their investigative units on allegations that relate to their waiver programs and associated providers.

Federal

Centers for Medicare and Medicaid Services (CMS) Center for Program Integrity (CPI) – The mission of CMS CPI is to detect and combat fraud, waste, and abuse in the Medicare and Medicaid programs. Working alongside providers, states, and other stakeholders, CPI supports accurate enrollment and billing practices. HFS OIG's work with CPI includes participating in monthly Technical Advisory Group calls with other states to discuss topics including fraud schemes, provider enrollment, data analytics, and managed care. CPI staff also work with HFS OIG, other states' program integrity units, and UPIC to provide audit and investigation assistance.

Department of Health and Human Services Office of Inspector General (HHS-OIG) – The HHS-OIG fights fraud, waste, and abuse in Medicare, Medicaid, and other HHS programs. Because HHS-OIG has jurisdiction over the federal Medicare program, it overlaps with HFS OIG's jurisdiction over the Illinois Medicaid program. If an HHS-OIG investigation implicates Illinois Medicaid providers, HFS OIG may provide information or otherwise support the investigation. Additionally, when an HHS-OIG investigation results in the federal exclusion of an Illinois Medicaid provider, HFS OIG takes reciprocal action to terminate that provider from the Illinois Medicaid program.

Department of Justice/Federal Bureau of Investigation/Drug Enforcement Administration – HFS OIG supports federal law enforcement agencies such as the Federal Bureau of Investigation (FBI), the Drug Enforcement Administration (DEA), and the U.S. Department of Justice in their Medicaid fraud investigations. HFS OIG serves as the primary liaison between these entities and the Illinois Medicaid program to coordinate data collection and policy research.

Contractors

Recovery Audit Contractor (RAC) – Illinois contracts with Gainwell, Inc. on a contingency-fee basis to conduct audits of state Medicaid claims for enrolled providers of goods and services under the traditional fee-for-service model. RAC audits identify overpayments and underpayments according to the State of Illinois plan. RAC overpayment determinations are referred to HFS OIG's collections unit or to OCIG for appealable issues.

Unified Program Integrity Contractor (UPIC) – UPIC is a no-cost resource to state Medicaid agencies established under the Federal Deficit Reduction Act. It authorizes external auditors to monitor and audit potentially fraudulent Medicaid claims as well as identify overpayments made to individuals or entities receiving federal funds. HFS OIG utilizes the UPIC auditor CoventBridge to conduct medical reviews, utilization reviews, and fraud inquiries. HFS OIG works with UPIC on its audits and acts in response to its findings, including issuing letters of education, recouping overpayments, and suspending or terminating providers.

Public-Private Partnerships

Healthcare Fraud Prevention Partnership (HFPP) – The HFPP is a voluntary public-private partnership that helps detect and prevent healthcare fraud through data and information sharing. Partners include the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and healthcare antifraud associations. HFS OIG is a participating member that uses HFPP's information sharing sessions, whitepapers, and studies to educate staff and develop potential leads for further inquiry.

National Association for Medicaid Program Integrity (NAMPI) – NAMPI was formed over 35 years ago by officials from various states interested in improving information sharing regarding Medicaid program integrity efforts. Today, NAMPI is composed of professionals from a wide variety of disciplines representing Medicaid programs from all 50 states. Through monthly information sharing sessions, regional meetings, trainings, and annual conferences, HFS OIG exchanges information on national trends and prevalent fraud schemes and provides staff with meaningful educational and training opportunities.

National Health Care Anti-Fraud Association (NHCAA) – NHCAA's mission is to protect and serve the public interest by increasing awareness and improving the prevention, detection, investigation, and civil and criminal prosecution of healthcare fraud and abuse. HFS OIG participates in NHCAA to further development of staff skills and to access information on national trends in healthcare fraud.

STAFFING AND PROFESSIONAL DEVELOPMENT

HFS OIG continues to undertake initiatives to foster the continuous growth and professional development of our staff.

HIRING AND STAFFING

Hiring and Staffing: In FY2024, HFS OIG hired 33 employees and promoted 10 individuals within the Office. At the end of the fiscal year, HFS OIG employed 144 staff. As of the publication of this report, there are 16 positions in the hiring process which--when complete--will have HFS OIG close to fully staffed. This growth is a great accomplishment that underscores our commitment to attracting top talent and enhancing our team's capabilities to further our program integrity efforts over the Illinois Medicaid program. To highlight one specific hiring success from the year, HFS OIG hired three new Nurse Analysts in the Peer Review Unit. This unit had experienced historical staffing shortages, which impacted its ability to meet its mission, so the hiring of these new employees was an important accomplishment for the Peer Review program.

PROFESSIONAL DEVELOPMENT

Through strategic professional development, certification, and training programs, HFS OIG prioritizes equipping its staff with knowledge, skills, and resources essential for thriving in their roles and driving HFS OIG's antifraud and program integrity efforts forward. Some FY2024 professional development accomplishments include the following.

Certifications and Credentials: Many HFS OIG staff are members of the Association of Inspectors General (AIG), a national organization of state, local, and federal inspectors general and their employees. AIG offers training seminars and certification institutes for members. HFS OIG staff attained the following designations in FY2024:

- 1 Certified Inspector General
- 10 Certified Inspector General Investigators
- 4 Certified Inspector General Auditors
- 2 Certified Inspector General Inspector/Evaluators

HFS OIG staff are encouraged to obtain professional certifications which will enhance their skill sets and directly assist with OIG related work product. In FY2024:

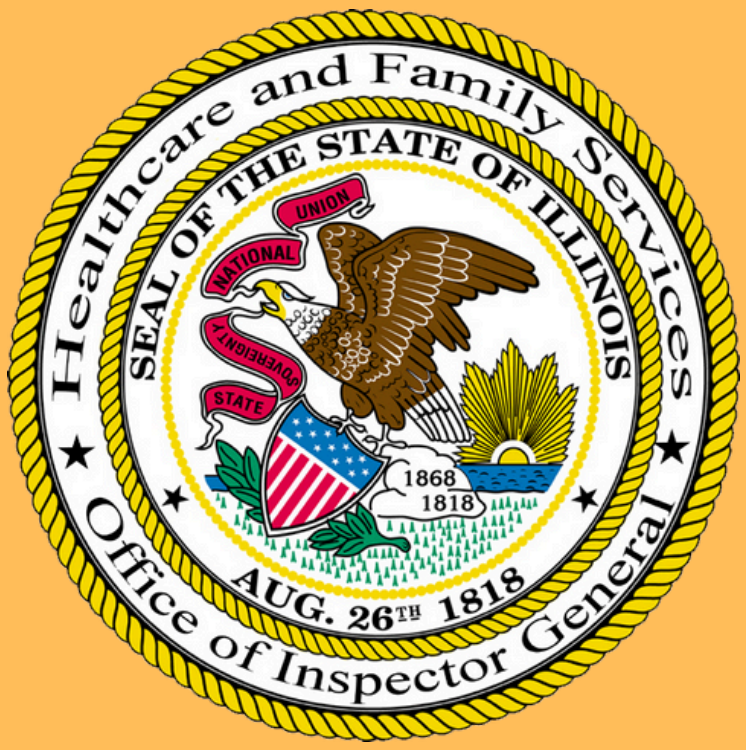
- Chief of Staff Stephanie Snow was sworn in as an attorney and counselor to the Bar of the Supreme Court of the United States.
- BOI Investigator Samantha McCarthy became certified as a P.E.A.C.E. Investigative Interviewer.
- GPSI Isaac Amponsah became a Certified Fraud Examiner (CFE).

Teaching and Presentations: OIG's participation in national learning sessions continued in collaboration with state sister agencies and national antifraud counterparts, like the NHCAA, NAMPI, HFPP, and the Medicaid Integrity Institute (MII). In FY2024, HFS OIG sent 34 staff to 11 in-person conferences and training boot camps, and nine staff to five virtual events. Notably in 2024, MII resumed in-person training sessions, and HFS OIG staff attended the Data Experts Symposium, the Coding for Non-Coders Training, and the Medicaid Provider Audit and Investigative Skills Symposium. In addition, Audit Manager Brenda Beal was a faculty member for the Coding for Non-Coders training. HFS OIG facilitated the intra-office sharing of 36 healthcare fraud related trainings, including presentations from the Illinois Association of Medicaid Health Plans, NHCAA, and HFPP.

In April 2024, Deputy Inspector General Anthony Florio, Chief Legal Counsel Nathan Kipp, and OCIG staff member Roth Colbert gave a presentation to the Illinois Chapter of the Association of Inspectors General titled *Ensuring Program Integrity in Home-Based Medicaid Services*. Also in April 2024, Inspector General Brian Dunn and BFST Bureau Chief Wei-Shin Wang presented *The State of Analytics* at the SAS Innovate annual conference.

Internships: HFS OIG continues to partner with the University of Illinois Springfield's Graduate Public Service Internship (GPSI) Program. GPSI pairs graduate students with State agencies like HFS and provides students with professional state government experience. Each internship opportunity is unique at HFS OIG, with interns working in a variety of bureaus and on a wide range of impactful program integrity work products. During FY2024, HFS OIG's 10 interns worked on a variety of projects including social media content development, statistical analysis of the MCO fraud reporting portal, data, and link analysis of specific fraud investigations, and assisted in the LTC-ADI appeal hearing process. Three GPSIs, assigned to BFST, are integrating new Power BI technology into HFS OIG's existing inquiry online system. Interns assigned to BMI created new individualized audit plan documents, performed coding research, and conducted research for potential cost saving changes documented in a draft whitepaper for management.

Criminal Case Activity



CRIMINAL CASE ACTIVITY

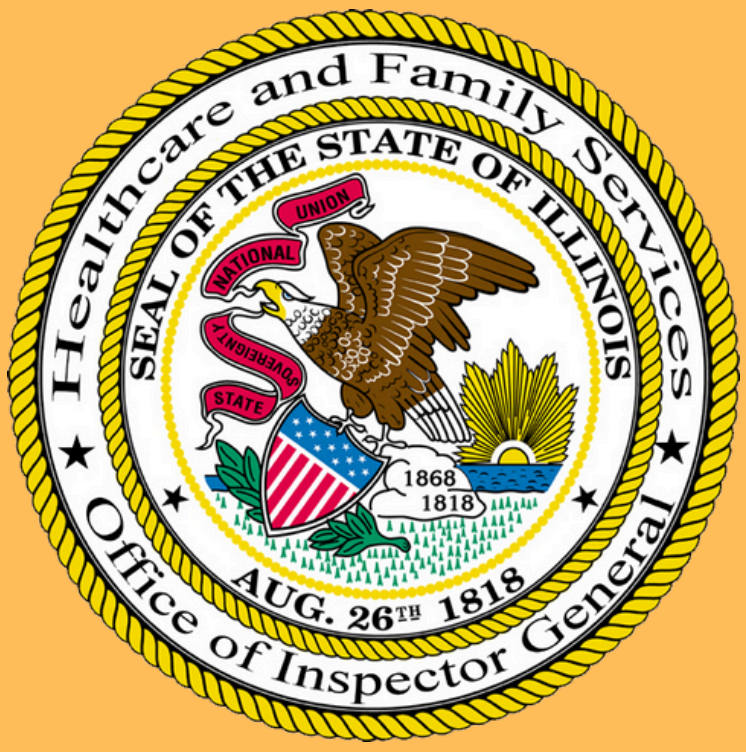
HFS OIG investigations and audits can uncover alleged violations of state or federal criminal laws, which may be prosecuted by the U.S. Attorney's Office, the Office of the Illinois Attorney General, or various State's Attorney's offices throughout the State. The following table summarizes ongoing criminal cases that arose from HFS OIG referrals to its law enforcement partners.[3]

OIG Case Number(s)	Criminal Case	Summary	Status
1392853	*People v. Smith* DuPage County 23 CF 1682-01	Lateena Smith, a psychologist, was charged for submitting $2.46 million in false Medicaid claims for psychotherapy services she did not provide.	On 8/8/2023, Smith was charged with 4 counts of theft, 1 count of managed health care fraud, and 1 count of forgery. The next court status is scheduled for 8/27/2024.
1380021	*People v. McTizic* Cook County 23 CR 03356 01	Juahana McTizic, a home care aide, was charged with vendor fraud, theft, and forgery for billing for services not rendered	On 9/6/2023, McTizic pleaded guilty to an amended count of theft and was sentenced to 18 months of probation, and restitution of $6,576.
1377232	*People v. Abdullah* Macon County 23-CF-1404	Paula Abdullah, a personal support worker, was charged with fraud after receiving over $30,000 in overpayments after submitting false timesheets for personal support services rendered while she was working secondary employment.	Abdullah was indicted on 9/22/2023. On 2/8/2024, she pleaded guilty to vendor fraud, and was sentenced to 24 months of felony probation and order to pay $30,738 in restitution.
1200352	*People v. McMiller* Cook County 20 CR 11336 01	Dr. William McMiller owned Dr. Bill's Learning Center, which offered tutoring services to children, as well as clinical therapy and psychiatric services. Dr. McMiller submitted numerous claims to the Illinois Medicaid program for psychotherapy and medical services that were not provided.	On 6/12/2024, Dr. McMiller was sentenced to eight 8 years of incarceration for his conviction on one count of vendor fraud and two counts of theft.

[3] Charges in indictments and criminal complaints are not evidence of guilt; defendants are presumed innocent and entitled to fair trials at which the government has the burden of proving guilt beyond a reasonable doubt.

OIG Case Number(s)	Criminal Case	Summary	Status
1370658	*People v. Sykes* Cook County 24 CR 01408 01	Monique Sykes, a Medicaid recipient, was charged with two counts of theft, one count of vendor fraud, and one count of forgery for submitting fraudulent timesheets and receiving a $4,710 overpayment.	Sykes was indicted on 2/1/2024. This case is set for a change-of-plea hearing on 8/26/2024.
1400273	*People v. Carter* Cook County 24 CR 06203 01	Cynthia Carter, a home care aide with IDoA, was charged with billing over $10,000 in services while her client was in-patient and after the client was deceased.	Carter was indicted on 6/21/2024. The next court date is scheduled for 8/29/24.
1313684	*People v. Booker* Cook County 21CR1277801 *People v. Thomas* Cook County 21CR1277701	Siobahan Booker (owner) and Doreatha Thomas (biller) of Integrity Medical & Physician Supply were charged with 2 counts of theft, 1 count of vendor fraud, and 1 count of forgery for fraudulent billing for durable medical equipment that was not provided to Medicaid recipients.	Booker and Thomas were indicted on 10/8/2021. On 6/22/2023, after a bench trial, they were found guilty of two counts of theft and one count of vendor fraud. On 10/18/2023, they were each sentenced to 6 years imprisonment. They have appealed their sentences.
1363001	*U.S. v. Ghosh* U.S. District Court, N.D. Ill. 23-cr-00140	Dr. Mona Ghosh was charged with 13 counts of healthcare fraud for submitting fraudulent claims for reimbursement for services that were not provided or for services that were not medically necessary.	Dr. Ghosh pleaded guilty on 6/27/2024 to two counts of health care fraud, in violation of 18 U.S.C. ∫ 1347. Sentencing is scheduled for 10/22/2024.
1364677	*People v. Cager* Cook County 22 CR 0362901	Crystal Cager, a Personal Assistant with DRS, was charged with vendor fraud and theft for billing over $10,000 for services not rendered while her client was in a long-term care facility.	On 1/30/2024, Cager pleaded guilty to Theft, a Class 1 Felony. Cager was sentenced to 36 months second chance probation, and was ordered to pay restitution in the amount of $9,000.
1320365	*People v. Dunbar* Massac County 21-CF-39	Amanda Dunbar, a recipient of public assistance in Massac County, failed to report that her husband, Jason Dunbar, had resided in the home of the public assistance unit and was receiving income from his employment.	On 6/15/2023, Dunbar pleaded guilty to one count of state benefits fraud and was sentenced to 24 months of second chance probation, ordered to pay restitution of $36,149, and fined $2,749.

Bureau of Medicaid Integrity



BUREAU OF MEDICAID INTEGRITY (BMI)

AUDITS

BMI's Audit Section performs post-payment audits of Medicaid enrolled providers to ensure appropriate payments and to prevent and recover overpayments. The Audit Section approaches auditing using various audit methodologies, which are tailored to identify the risk of loss, based on changing trends. All enrolled providers are subject to audit. The selection of a provider for audit review is based on several factors, including, but not limited to data analysis, external complaints of potential fraud or improper billing, and provider risk scores and categories. Audits may use statistically valid random samples to allow its findings to be extrapolated. BMI audits hospitals, pharmacies, nursing homes, laboratories, physicians, transportation providers, and durable medical equipment (DME) suppliers. Where audits identify an irregularity in the billing practices of a provider, OIG may request that the provider conduct its own investigation and overpayment self-disclosure. Alternatively, an enrolled provider may also submit a self-disclosure based on findings identified pursuant to an internal investigation and review of the provider's billing practices.

The Audit Section has oversight responsibility for RAC and UPIC. RAC reviews fee-for-service paid claims for compliance with state rules and regulations. The UPIC conducts investigations and audits to reduce fraud, waste, and abuse in Medicaid programs. Audits conducted by BMI, RAC, and UPIC may result in the recoupment of identified overpayments, entry into a corporate integrity agreement, termination from Medicaid, or referral to MFCU for prosecution.

FY2024 AUDITS HIGHLIGHTS

In-House Audit Highlights: The FY2024 in-house audit plan consisted of audits of physicians, clinical social workers, transportation companies, DME companies, home health agencies, LTC facilities, pharmacies, nurse practitioners, optometrists, laboratories, and post-mortem desk audits. Case highlights include audits of two transportation providers resulting in identified overpayments of $284,902 and $472,854. The findings were related to missing documentation, documentation that did not support services billed, no corresponding medical services, and insufficient proof of vehicle registration. One of the transportation providers refused to cooperate and was non-compliant with submission of documentation. In another BMI audit of a DME provider, the auditors identified an overpayment of $318,759 resulting from missing documentation for the services billed. BMI completed ten post-mortem audits with the highest identified overpayment of $129,126. A physician audit resulted in an identified overpayment of $106,487 due to non-compliance with audit requests for medical records.

Nursing Home Audits: The long-term care unit's FY2024 audit plan consisted of 32 providers—31 Immediate Care Facilities/Developmentally Disabled (ICF/DD) and one supportive living facility. Out of the 32 facilities, 18 were audited for the first time. For

FY2024, all 32 audits were initiated, and 19 audits have been completed and payment agreements issued. The identified overpayments to-date total $489,681 with the highest identified overpayment of $103,560. The remaining audits will be completed in FY2025.

Provider Self-disclosures: The federal Patient Protection and Affordable Care Act (ACA) requires providers to timely identify and repay Medicaid overpayments. Under the ACA, providers are obligated to report, explain, and repay overpayments within 60 calendar days of identification. OIG monitors a self-disclosure protocol that allows providers to voluntarily refer such overpayments upon detection to avoid penalties and sanctions. In FY2024, providers identified and repaid approximately $526,581 to the Department through self-disclosure. Some highlights include a long-term care company that identified three of its facilities received overpayments of a $260,518, $84,578, and $21,003 by failing to update the patient liability amount in the Medicaid system, resulting in the facilities receiving Medicaid payments which overlapped with patient liability received from the resident. In another case, a hospital reported a $33,909 overpayment related to the utilization of Current Procedural Terminology (CPT) code J9271 – Injection, Pembrolizumab, 1mg.

Audit Efficiencies: In FY2024, BMI continued to improve audit outcomes, streamline audit processes, and decrease staff time spent on labor intensive manual tasks. Some examples include:

- BMI examined the statistically valid random sample size to determine whether the number of claims and medical records could be reduced while still maintaining auditing standards. After consideration, BMI reduced the sample size and record requirements for most in-house audits. This reduction of the audit sample size has lowered the burden on providers and the average time for an auditor to complete their audit reviews.
- BMI worked with the Bureau of Fraud Science and Technology to create an automated report in the Dynamic Network Analysis system to consolidate information on recipients and room and board for long-term care audits. This decreased staff audit preparation time, increasing efficiency and consistency in nursing home audit.
- To increase uniformity, improve ease of audit reporting, and streamline internal documents, BMI management reviewed and created preliminary and final audit report templates and updated internal reports and documentation. These changes increased audit efficiency and decreased staff audit completion time.

Interdisciplinary Committee (IDC) and BOI Case Coordination: In FY2024, BMI was instrumental in establishing an IDC with a mission to develop and support cases that require expertise across OIG and result in impactful outcomes, high visibility, and greater capacity. The IDC's primary goals are to 1) promote and foster interdisciplinary collaboration between BMI, BOI, BFST, and OCIG; 2) support development of research and data to identify high-risk target areas for audits and investigations; 3) increase the use of research methods to further FWA and compliance investigations; and 4) disseminate information

related to current and future cases across OIG disciplines to ensure engagement of relevant expertise. In FY2024, the IDC considered 29 cases. BMI Audits and BOI collaborated on an investigation of four providers (two pharmacies and two physicians) for potential kickbacks and potential inappropriate inter-relationships. This collaboration led to a referral of all four providers to law enforcement.

Contractors

Unified Program Integrity Contractor (UPIC): UPIC, operating under a Joint Operating Agreement, works with both OIG and CMS to identify overpayments made to providers or entities receiving federal Medicaid funds and to determine if fraud, waste, or abuse occurred. For FY2024, BMI continued to enhance the process and relationship between OIG and Midwest UPIC contractor CoventBridge. Stronger communication, validation and vetting processes developed. CoventBridge provided proactive studies for OIG consideration. In addition to new studies found by UPIC, HFS OIG submitted 20 referrals to CoventBridge of which 14 were accepted. In collaboration with CoventBridge, BMI developed a pharmacy discrepancy tool so that UPIC can begin auditing pharmacies in FY2025.

UPIC Case Highlights: In FY2024, UPIC audited a variety of provider types, including DME companies, physicians, mental health providers, transportation companies, and hospitals. Case highlights include:

- A traumatic brain injury provider audit (Case No. 1391879) resulted in an identified overpayment of $520,894. The provider's documentation did not support the services billed. The provider agreed to the results and entered into a payment agreement.
- A physician audit (Case No. 1268630) resulted in an identified overpayment of $48,278. The provider agreed to the results and entered into a payment agreement.
- A DME provider (Case No. 1278830) sent rebuttal documentation in response to findings. CoventBridge completed a second medical review and upheld their decision. This case was referred to OCIG with an identified overpayment of $15,288.

Recovery Audit Contractor (RAC): The Medicaid RAC program was implemented pursuant to section 6411(a) of the Affordable Care Act, which amended and expanded section 1902(a)42 of the Social Security Act (the Act) to require States to establish Medicaid RAC programs by December 31, 2010. The final rule for Medicaid RAC was effective January 1, 2012, with States being required to fully implement RAC programs by April 1, 2011.[4] Health Management Systems, Inc. ("HMS"), a Gainwell Technology Corp., is the Illinois Medicaid RAC contracted by HFS OIG to conduct post-payment audits of vendors enrolled in the Illinois Medical Program.

[4] *See* final rule at: https://www.govinfo.gov/content/pkg/FR-2011-09-16/pdf/2011-23695.pdf.

FY2024 was the start of a new RAC contract and implementation of priorities identified during FY2023. BMI reviewed and implemented RAC processes and protocols and oversaw the RAC program. HFS OIG approved two complex audit scenarios for the RAC—Diagnosis Related Groups audits and Place of Service audits:

1. Diagnosis Related Groups (DRG) – The RAC audits DRG codes related to a medical procedure. The RAC performs a comprehensive medical coding review pursuant to Current Procedure Terminology (CPT) codes in effect at the time of service of all DRG coding claims for which an improper payment is identified. DRG audit findings contested by a provider are subject to clinical review by a contract physician.

2. Place of Service Review – Medical records are closely examined by nurses and physicians in a post-payment review to ensure that claims for treatment furnished to an Illinois Medicaid Program recipient by an enrolled provider meet the Department's utilization review requirements for payment. Specifically, the audit determines whether services furnished on an in-patient basis could have been effectively furnished more economically in a setting other than inpatient.

Both complex audit scenarios involve an individual review of the medical record or other documentation submitted by the provider in support of the claim. By the end of FY2024, RAC reviewed 22,959 complex claims pursuant to these audit scenarios.

FY2024 AUDITS STATISTICS

In-House Audits

Initiated: 54
Completed: 49
Total Overpayments Identified: $2,540,794
Payment Agreements Signed: 27
Referrals To OCIG For Legal Action: 22

Contractor Audits

RAC

Claims Initiated: 22,959
Claims Completed: 8,032
Total Overpayments Identified: $33,026,327
Referrals to OCIG for legal action: 173 claims (identified overpayment of $973,934)

UPIC

Initiated: 13
Completed: 11
Total Overpayments Identified: $623,057
Referrals to OCIG for legal action: 2

DentaQuest

Referrals to DentaQuest: 8

Cases monitored: 13

Self-Disclosure

Total number of self-disclosures reported: 39

Total overpayments identified and aid: $526,581

PEER REVIEW

The Peer Review Unit (PRU) consists of nurses and physicians tasked with conducting utilization and quality-of-care (QOC) reviews of healthcare furnished to Medicaid clients by providers such as physicians, dentists, podiatrists, audiologists, chiropractors, nurse practitioners, and optometrists. QOC concerns include risk of harm (the service as the result of medical care or lack thereof presents potential harm to the patient), excess of needs (medically unnecessary or excessive care), and grossly inferior quality of care (care that is below the minimum standards necessary to treat a patient). PRU cases originate from hotline complaints, referrals from internal units and/or external agencies such as IDFPR, IDPH, the Illinois State Police, or MCOs.

PRU's nurse analysts determine what services are in question by the referral allegation. Data analytics are then used to identify recipients who received those services from the provider under investigation. PRU nurses and HFS physician consultants perform in-depth record reviews to determine if documentation meets acceptable quality guidelines, supports the level of service billed to the Department and was medically necessary. When minor concerns are noted during this review process, the Department sends a letter to the provider indicating areas needing improvement and guidance for the recommended improvement. However, if the identified concerns are more serious, the provider may be required to appear before the Medical Quality Review Committee (MQRC) where physician consultants question the provider to determine if appropriate care was rendered to Medicaid clients.

After an MQRC review, the Committee makes a recommendation to OIG regarding the appropriate action, which includes sending a letter to the provider identifying concerns; requiring the provider to implement corrective action within a certain time period; referring the matter internally or externally for further action; recommending administrative action, such as termination, entry of a corporate integrity agreement, suspension, or denial of reinstatement or enrollment; or closing the matter with no further action. OIG considers the Committee's recommendations and notifies the provider of the final decision.

In addition to reviewing complaint referrals, the nurse analysts frequently conduct joint interviews with BOI investigators to obtain additional clinical information needed to fully evaluate the referral and make clinical recommendations. PRU also conducts quality-of-care

reviews for any providers that submit a Medicaid enrollment application and were previously terminated, suspended, or withdrew from the Medicaid Program, or had an action/discipline noted on their license.

FY2024 PEER REVIEW HIGHLIGHTS

Medical Quality Review Committee (MQRC): The MQRC reviewed five cases for quality-of-care concerns identified during the initial review process. All five MQRC meetings were conducted by the newly implemented virtual process. From these reviews, three providers received Letters of Education indicating needed improvements in their care or documentation, one provider was denied reinstatement into the Illinois Medicaid Program and one provider received a Letter of No Concerns indicating there were no deficiencies found in the current review of his practice.

Recipient Verification Program (RVP): The RVP is a federal mandate for Medicaid Programs to verify with recipients that services billed by providers were received. Under the OIG's RVP process, PRU sends approximately 500 verification letters to recipients monthly. The selection criteria were recently changed from randomly selected services to purposely selecting those services identified in common fraudulent billing schemes. Services involving sensitive subject matter are excluded from the verification process. Results and responses to letters are reviewed and evaluated for any necessary follow-up. Those returned as "undeliverable" were logged and sent to the respective regional office.

FY2024 PEER REVIEW STATISTICS

Cases Reviewed: 26

- Quality-of-Care reviews: 23
- Reinstatement reviews: 3

Case Review Outcomes

- Quality-of-Care reviews outcomes
  - Letter of education: 4
  - No further action/no concerns: 9
  - Allegations unsubstantiated: 3
  - Audit referral: 1
  - Refer to OCIG for termination: 1
  - Refer to MQRC: 5
- Reinstatements approved: 3

Medical Quality Review Committee Outcomes: 5

- Letter of Education: 3
- Letter of No Concern: 1
- Deny Reinstatement: 1

Recipient Verification Program

Letters mailed: 8,500
Responses received: 498
Services reported not received: 21
Letters returned as undeliverable: 505
Referrals to regional offices: 198 (starting December 1, 2023)

QUALITY CONTROL

Quality-Control Review (QC) oversees the federally mandated Medicaid Eligibility Quality Control (MEQC) program and the Payment Error Rate Measurement (PERM) initiative. In addition, QC conducts Independent Reviews of eligibility determinations and special projects designed to better identify error-prone medical eligibility factors, evaluate the effectiveness of eligibility policies and procedures when compared to federal regulations, and develop strategies to reduce medical eligibility errors across the state.

The MEQC program focuses on improving the quality and accuracy of Illinois' Medicaid and Children's Health Insurance Program (CHIP) eligibility determinations through triennial reviews covering a span of one calendar year. The MEQC program is intended to complement the PERM program by ensuring state operations make accurate and timely eligibility determinations so that Medicaid and CHIP services are appropriately provided to eligible individuals.

The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. The PERM is conducted every three years. QC conducts the eligibility reviews for MEQC and aids the federal auditors for PERM. QC is responsible for the coordination of the completion of questionnaires, data forms, contractor systems access, and identification of the universe of claims for federally contracted auditors. QC also acts as the liaison between the Department's staff responsible for the payment of claims and the federal auditors for PERM.

In addition, QC coordinates the development and monitoring of corrective action plans designed to eliminate or reduce errors utilizing various methods including training, system programming, and policy changes.

FY2024 QUALITY CONTROL HIGHLIGHTS

Internal and External Communications QC took strides in increasing communication with internal and external stakeholders. Projects implemented during FY2024 were the creation of an internal provider database to be used by all BMI units which validated the location of medical records for PERM Medical Records sampled claims; revised communication processes with units outside of the OIG for PERM, MEQC, and Independent Review findings to encourage and more efficiently track collaborative efforts; increased QC involvement, interaction, and audit tracking for PERM Data Processing and

Medical Record Reviews; creation of a PERM informational page to the HFS OIG website to inform the public, state offices, and medical providers about PERM reviews and the processes for each review type; and creation the first annual QC Error Notification Webinar (notification of frequently identified errors in the past 12 months) and the first triennial informational QC Webinar (informs staff of the purpose of QC projects as well as the role QC and eligibility staff play in reducing medical error rates) to HFS and DHS Eligibility Staff. Both webinars were part of the MEQC Review Year (RY) 2023 Corrective Action Plan submitted to CMS.

Projects with HFS Bureau of Professional and Ancillary Services: QC, in collaboration with BPAS, assisted in the HHS audit of telehealth claims through data support and provider outreach. At the end of the project, HFS was in full compliance with medical records requests.

PERM RY22 and MEQC RY23 Corrective Action Plans: QC participated in the identification of providers from the RY2022 PERM cycle who were subject to recoupment of sampled claim funds due to failure to provide sufficient medical records for review. QC coordinated and tracked the implementation of 14 corrective actions.

Illinois Residency Reviews (IRR): QC restructured residency reviews to access additional data sources and coordinate findings with other states when there is overlapping Medicaid eligibility.

FY2024 QUALITY CONTROL STATISTICS

Independent Reviews: 136

Illinois residency reviews: 1,567

Verified residency: 709
Unable to verify residency: 774
Cost avoidance based on verifications: $1,893,071

PERM Medical Record Reviews: 112

LONG-TERM CARE – ASSET DISCOVERY INITIATIVE

The Long-Term Care – Asset Discovery Initiative Unit (LTC-ADI) conducts reviews of long-term-care applications with indications of the transfer or non-disclosure of assets. Undisclosed assets are resources not reported during the application process for long-term care services through the Medicaid program. If LTC-ADI identifies undisclosed resources, the applicant must spenddown those resources prior to Medicaid's payment for services. Transfers of assets for less than fair market value result in penalty periods during which the recipient is ineligible to receive long-term care services. LTC-ADI reviews applicants' financial documents, trusts, and other legal records to determine if they meet current policy

requirements. By preventing improper conduct related to eligibility, LTC-ADI ensures program funds go to qualified applicants who do not have the means to pay for their own care. Adverse determinations may be appealed in an administrative hearing. LTC-ADI provides expert testimony in appeals involving excess resources, penalties, denial of applications, and cancellation of ongoing eligibility. Most appeals are withdrawn by the client due to verifications received or adjustments executed. For those appeals that result in a hearing, the final determination is implemented by the local DHS Family Community Resource Center.

FY2024 LTC-ADI HIGHLIGHTS

Community Spousal Support Cases: Over recent years, an increasing number of long-term care applicants were submitting formal notices that their spouse living in the community was refusing to support them and assigning their support to the State. This meant that the spouse's resources could not be considered in determining the applicant's eligibility. HFS's recourse to these refusals under the law is to seek a spousal support order, a process that previously had not been implemented. Pursuant to 305 ILCS 55-4(b) and 89 Ill. Admin. Code 120.379, in May 2024, LTC-ADI in cooperation with OCIG began issuing support orders to community spouses, who had refused support. In FY2024, twenty support orders were issued with a total collection of $248,205. Since the implementation of spousal support orders, the submission of new spousal refusal notices has slowed significantly.

Redetermination revealed investment accounts (Case No. 1410287): LTC-ADI reviewed the eligibility redetermination of a client, who was approved for LTC services during the public health emergency based on his self-attestation as to his financial eligibility. Upon his redetermination, LTC-ADI identified that the client had two Charles Schwab accounts—one with $3.6 million and the other with $3.3 million. The client had been receiving Medicaid services with $7,105,730 in assets. LTC-ADI's review resulted in the suspension of his Medicaid long-term care services.

Caregiving, annuities, and missing funds (Case No. 1402221): In this case review, LTC-ADI discovered the applicant paid the son and daughter for caregiving services but exceeded the reasonable amount of payment. In addition, the applicant's property sold, but instead of putting the funds into the applicant's account, the children kept the money. Also, the applicant had two annuities that were not actuarily sound, meaning they would surpass her lifetime. Finally, there were two annuities that the applicant transferred to her children. The total penalties for this case were $453,535.

Multiple transfers to the children including a life estate (Case No. 1403350): The community spouse applied for the applicant's LTC services. In a case review, LTC-ADI discovered they gave their children assets in the form of checks and a Quit Claim Deed of property within the five-year lookback. Since the transfer occurred within the five years and the applicant and community spouse received no funds, these transfers resulted in a penalty. In addition, the applicant and community spouse owned another property that was sold to

their daughter and her husband for below fair market value. Total penalties in this case were $173,851.

Transfer of property and funds (Case No. 1402320): During its review, LTC-ADI found that the applicant owned half of an interest in a property with a value of $600,000. Within months of applying for Medicaid the applicant Quit Claim deeded his share of the property to his daughter creating a penalty of $300,000. In addition to this transfer, checks and withdrawals were taken from his account and given away. The total amount of the penalty was $331,101.

Missing funds (Case No. 1402764): Upon review of the applicant's application, LTC-ADI found that the applicant had a CD with a large value held at the same bank where she had other accounts. Three months before she applied for Medicaid, the applicant surrendered the CD and the funds disappeared. The applicant also had a vehicle that was transferred, and she did not receive fair market value. The total amount of the penalty was $177,228.

Farm ground and other excess resources (Case No. 1402705): Upon review of the application, LTC-ADI identified undisclosed farm property. The applicant had 39 acres of farm ground that had a value of $233,183 as per University of Illinois farmland valuation. The applicant also owned $27,528 in Edward Jones investment accounts. In addition, the applicant held oil rights, stocks, and life insurance. In total, the applicant had $323,735 in assets to pay for his own care before the State would need to pay on his behalf.

Identified investment accounts (Case No. 1408692): During its review, LTC-ADI discovered that the applicant's community spouse had a Charles Schwab account with a value of $710,077. In addition to the investment account, the spouse had an IRA account of $64,478 The applicant had excess resources of $718,020 to pay for their care.

Redetermination resulted in suspended services (Case No. 1407226): The client was approved for LTC services during the PHE based on self-attestation. Upon its review, LTC-ADI identified that the client's community spouse owned multiple properties. Many of these properties were of commercial use, had active leases, and were worth several million dollars. The community spouse refused to cooperate with HFS OIG, and the client's case was closed. The community spouse appealed the closure but later withdrew his appeal.

FY2024 LTC-ADI STATISTICS

Applications Reviewed: 1,733

LTC-ADI Recommendations on Applications Reviewed

Penalty and spenddown: 116
Penalty/no spenddown: 347
No penalty/spenddown: 173
No penalty/no spenddown: 396

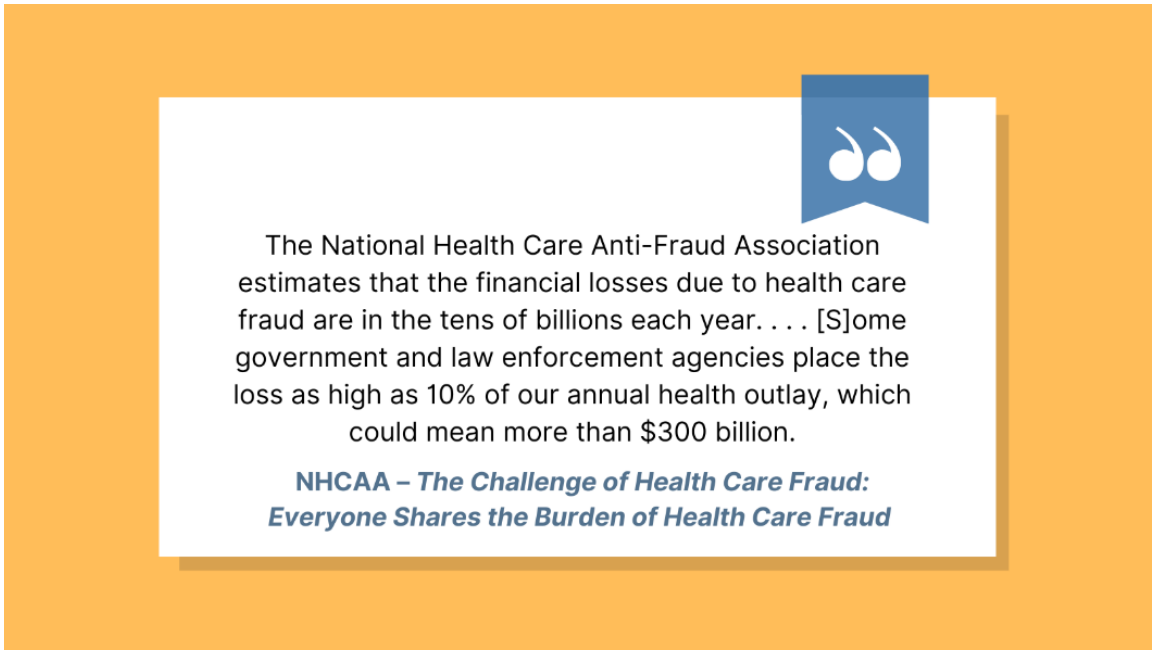
Denied: 643
Withdrawn: 58
Rejected:[5] 253

Cost Savings From LTC-ADI Review

Value of unallowable transfers (penalties): $34,722,690
Value of excess resources (spenddowns): $24,843,291
Cost Avoidance: $45,156,753

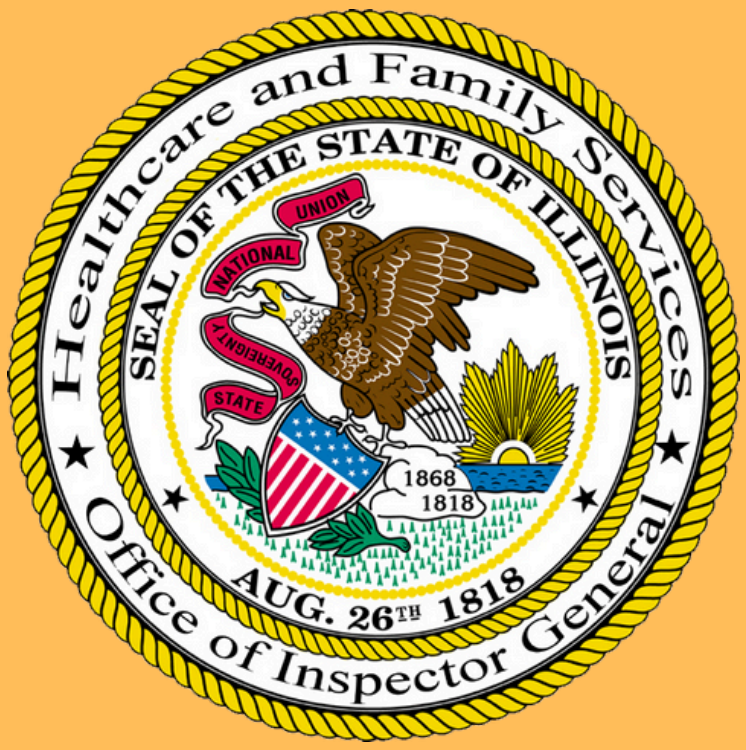
Spousal Support Orders

Value of Orders: $1,056,510
Collections on Orders: $248,205



[5] Application rejections typically occurred if the client was deceased during the application review.

Bureau of Investigations



BUREAU OF INVESTIGATIONS (BOI)

COMPLAINT INTAKE UNIT

BOI's Complaint Intake Unit (CIU) serves as the central intake unit for HFS OIG. CIU processes referrals and complaints received from MCOs, local DHS offices, members of the public, and other stakeholders alleging fraud and abuse by providers and recipients of Medicaid services and other government benefit programs. Referrals or complaints are processed via phone hotline and online portals, as well as through direct communication with state and federal agencies and law enforcement entities.

CIU conducts thorough research on fraud and abuse allegations by reviewing internal Medicaid data and by accessing databases from a variety of sources, including, but not limited to open sources, DHS, the Illinois Secretary of State, IDPH, the Illinois Department of Employment Security, and HFS's Division of Child Support Services. HFS OIG then determines what further action to take on the allegation, based on factors and criteria such as OIG's jurisdiction and resources, financial loss amount, and quality of care/patient harm.

FY2024 CIU STATISTICS

Complaints Received: 2,285
- Fraud Hotline: 233
- MCO Fraud Reporting Referrals: 671
- OIG Website: 1,206
- Other (email, mail, fax): 175

Complaints Closed on Initial Review[6]: 713
- Beneficiary: 521
- Provider: 192

Complaints Accepted for Further Review:[7] 1,562
- Beneficiary: 514
- Provider: 1,048

Provider Complaint Dispositions: 1,048
- Opened: 317
  - Investigations: 240
  - Audits: 30
  - Peer Review and Analysis: 23
  - FAE criminal referral: 14

[6] Complaints closed on initial review include matters that are duplicative, unintelligible, misdirected, or unrelated to OIG's jurisdiction.
[7] Some complaints reviewed in FY2024 were received in FY2023.

OCIG Termination/Exclusion: 5
MCO Audit/Investigation: 5

Referred or declined:[8] 731

Beneficiary Complaint Dispositions: 514

Unfounded:[9] 467
Investigation Opened: 36
Referred to BMI LTC-ADI: 1
Referred to External Partners: 10

INVESTIGATIONS

BOI's Investigations Section conducts investigations into fraud, waste, and abuse in programs administered by HFS, DHS, and IDoA. BOI is divided into four regional units – Southern, Central, Northern, and Cook County. In its investigations, BOI may work with the Illinois Medicaid Fraud Control Unit, state and federal prosecutors, members of the law enforcement community, and other state and federal regulatory agencies. As the result of BOI's investigation against a provider, HFS OIG may refer the matter for criminal prosecution or seek administrative sanctions through OCIG. BOI also continues to investigate recipients alleged to have engaged in eligibility fraud or abuse of their benefits from Medicaid, TANF, or the Child Care Program. These investigations may result in the identification of overpayments, termination of benefits, or prosecution by state and federal agencies. In FY2024, BOI completed a transition of SNAP fraud investigations to DHS, the state agency that administers the SNAP program.

FY2024 INVESTIGATIONS HIGHLIGHTS

Medicaid Provider Cases

Behavioral Health Provider misappropriated over 1 million dollars in false Medicaid claims (Case No. 1403658): An HFS OIG referral to MFCU alleged that a behavioral health provider headquartered in Chicago, Illinois was purporting to be following the requirements of the State's Supported Employment Program, which was developed to expand and enhance opportunities for individuals with intellectual and developmental disabilities. The investigation found that between May 1, 2020, and June 30, 2023, the company claimed to provide services, such as on-site job coaching, that were not rendered and received payments totaling $1,188,749. MFCU accepted the case for criminal investigation.

[8] Complaints are referred when OIG lacks jurisdiction, or another agency is better situated to investigate the matter. HFS OIG refers complaints to sister agencies like DHS and the IDoA, the MCOs, and other agencies as appropriate. Complaints are declined when, after OIG's review and assessment of the allegations, the complaint is found to be duplicative, no violation occurred or was *de minimis,* or factually does not warrant further investigation.
[9] Beneficiary fraud complaints are unfounded when, after CIU's review, OIG is unable to substantiate the allegation.

Personal Support Worker paid for over $48,000 in false billings (Case No. 1408491): An investigation found that a person employed as a provider for both DHS-DRS and DHS-DDD had extensive overlap of hours while working fulltime for another home health company. The OIG investigation found that the provider claimed to be in two and sometimes three places at once and billed on several occasions for more than 24 hours in a single day. Approximately $48,328 Medicaid funds were overpaid, and the case was referred to MFCU and accepted for criminal investigation.

Waiver Provider customer indicted for submitting false timesheets (Case No. 1370658): HFS OIG concluded that a Personal Assistant was paid for hours worked for two separate customers after the PA's death on April 16, 2020. Per Illinois Comptroller records, the deceased PA was issued vendor payments in January and February 2021 totaling nearly $4,000. These payments were paid via a State-issued debit card. The investigation determined that one of the PA's customers, Monique Sykes, transferred funds from this account to a personal U.S. Bank account. Thus, the evidence showed that customer Monique Sykes submitted or caused timesheets to be submitted after the PA's date of death to fraudulently obtain payment for services not rendered. This case was referred to and accepted by MFCU in October 2023. In February 2024, Sykes was indicted in Cook County Circuit Court for two counts of theft, one count of vendor fraud, and one count of forgery.

Personal support worker indicted for $15,000 in false billings (Case No. 1400273): HFS OIG concluded that Cynthia Carter was a home care aide employed by an agency through IDoA's Home and Community Based Services Waiver Program. OIG's investigation revealed that Carter continued to bill for services provided to the client while the client was in-patient and after the client's death in July 2022. Carter was paid approximately $15,000 for services not rendered. This case was referred to and accepted by MFCU in November 2023. In June 2024, Carter was indicted in Cook County Circuit Court on one count of vendor fraud and two counts of theft.

Transportation Provider billed for noncorresponding services (Case No 1368180): An OIG investigation of a non-emergency transportation company found that from October 2020 through May 2021, the provider billed for 1,811 dates of service for a recipient totaling $65,486. OIG's investigation determined that these dates of service had no corresponding medical claims to support the transportation services received. The clinical analysis also found other recipients with transportation services and no corresponding medical data, illogical trip times and possible transportation services billed and not rendered. This case was referred to MFCU and accepted for investigation.

Recipient caused false bills to be submitted indicating his daughter was caring for him as his personal assistant (Case No. 1403072): An OIG investigation found that a DHS-DRS recipient was collecting benefits by falsely stating his daughter was providing services to him as his Individual Provider (IP). It was alleged the daughter never worked for her father and had fulltime employment outside of the state of Illinois that contradicted her

working for her father. The investigation focused on employment records, social media posts, bank records, Secretary of State records as well as interviews. OIG referred the case to MFCU with a potential total overpayment of $154,468. The referral was accepted by MFCU for further investigation.

Home care aide billed for services while customers were in long-term care facilities (Case No. 1386092): An OIG investigation involving an agency with IDoA's Community Care Program found the home care aide was paid $5,979 in Medicaid and $6,699 in non-Medicaid dollars for allegedly providing home care services for two customers while they were inpatient in long-term care facilities. The investigation found that from June 14, 2017 through March 28, 2022, the home care aide continued to submit falsified documents to the agency indicating that services were being provided. This case was submitted to MFCU and accepted for further investigation.

Personal Support Worker (PSW) billed services while member resided in a skilled nursing facility (Case No. 1405874): In October 2023, the OIG received information from DHS-DDD regarding potential fraud involving a member. Specifically, DHS-DDD reported that a Personal Support Worker (PSW) continued to bill for services despite the member being admitted to a Skilled Nursing Facility on September 27, 2022, where the member currently resides. According to DHS-DDD records, the PSW billed for 1,142 hours of in-home services that were never provided to the member during this period. Additionally, OIG's investigation revealed that the PSW had secondary employment that conflicted with the PSW's hours. The investigation resulted in an estimated overpayment of $23,899. The case was subsequently referred to and accepted by MFCU.

DRS customer engaged in identity theft to create fictitious provider and obtain payments for services not rendered (Case No. 1402345): OIG completed an investigation involving a DRS IP wherein it was determined the customer falsely applied for the IP and reported the IP lived in the member's home. The customer further orchestrated the scheme to have the DRS payments flow into an account the customer controlled. An overpayment of services was established totaling $28,783 from December 2021 through December 2022. This case was referred to MFCU and accepted for investigation.

Dentist billed for services while in Mexico (Case No. 1373000): OIG completed an investigation involving a Medicaid dental provider where it was determined the provider was billing for dental services while not present in the office. OIG's investigation reviewed U.S. border crossing records and compared them with claims data to identify dates where it was impossible for the service to have been provided. An overpayment of dental services was estimated between $197,000 to $271,000 from 2018 to 2023 based on the dates the dentist was abroad. This investigation was referred to and accepted by MFCU.

Individual Provider billed for services while at secondary employment (Case No. 1398538): OIG completed an investigation involving an IP who received approximately $57,000 for allegedly providing IP services for the member while on the clock for a

secondary employer. Further, the IP and the member colluded to split the payments. This investigation found during November 2020 through July 2023, the personal assistant had approximately 3,396 hours billed as a personal assistant while simultaneously being clocked in as working at the secondary employer. This investigation was referred to and accepted by MFCU.

Childcare Cases

Childcare provider fraudulently billed for services while working another job in a different city (Case No. 1403345): OIG completed an investigation involving a childcare provider that was paid for services while working another job in a city two hours away. This investigation also found the childcare provider falsely reported her address and that the customer falsified paychecks to receive childcare assistance. The investigation resulted in an estimated overpayment of $58,703 from December 2021 through March 2023.

Childcare recipient fraudulently received assistance while responsible relative was gainfully employed (Case No. 1403547): An OIG investigation revealed that a childcare recipient received DHS childcare benefits for her children from September 2022 to May 2024. The investigation found that the recipient did not disclose that her husband, who is the father of the children, lived with them and had unreported earned income. The investigation resulting in an estimated overpayment of $45,079 for the period spanning September 2022 to May 2024.

Childcare recipient fraudulently received assistance while receiving monies from unreported income (Case No. 1402486): An OIG investigation found that a childcare recipient received assistance for her children from August 2021 through November 2023 after failing to report a responsible relative was residing in their residence with unreported employment income. The investigation also determined the childcare recipient had not reported the responsible relative was a business partner for her reported self-employment income. The investigation also determined the childcare recipient had additional unreported income from short-term rental properties. The results of the investigation established an estimated overpayment of $37,257.

Childcare recipient fraudulently received assistance by falsifying employment documents (Case No. 1402787): A completed OIG investigation found a childcare recipient falsified paychecks to receive childcare assistance. The investigation resulted in an estimated overpayment of $68,024 from November 2021 through May 2023.

Client Eligibility Cases

Conviction for benefits fraud with $36,000 restitution (Case No. 1320365): In July 2023, HFS received the first partial restitution payment after HFS OIG concluded that Amanda Dunbar, a recipient of public assistance in Massac County, failed to report that her husband, Jason Dunbar, had resided in the home of the public assistance unit and was receiving

income from his employment with Continental Tire the Americas, LLC. In June 2023, Dunbar pleaded guilty to one count of State Benefits Fraud and was sentenced to 24 months of second chance probation, ordered to pay restitution of $36,149, and fined $2,749 including court costs and associated fees.

FY2024 INVESTIGATIONS STATISTICS

Outcomes of Investigations Completed: 322

- Provider Cases: 112
  - Medicaid Cases: 89
    - Substantiated: 57
      - Referred to MFCU: 44
      - Referred to OCIG: 11
      - Referred to IDOA: 2
    - Substantiated/Threshold Not Met: 2
    - Unsubstantiated: 30
  - Childcare Cases: 3
    - Substantiated: 1
    - Unsubstantiated: 2
  - Administratively Closed/No Further Action: 20

- Beneficiary Cases: 210
  - Medicaid Cases: 203
    - Substantiated: 90
    - Unsubstantiated: 113
  - Childcare Cases: 7
    - Substantiated: 3
    - Unsubstantiated: 4

- Established Provider Overpayments: $26,418,144

- Established Client Overpayments: $2,011,014
  - Medicaid Beneficiary cases: $1,133,772
  - Childcare program cases: $209,053
  - SNAP overpayments: $596,730
  - TANF overpayments: $71,459

- Prosecutions in Beneficiary Cases
  - Established restitution in criminal actions: $42,807

Open Investigations at Close of FY2024

- Beneficiary Cases: 80
  - Medicaid cases: 68
  - Childcare cases: 12

Provider Cases: 257
Medicaid cases: 245
Childcare cases: 12

FRAUD ABUSE EXECUTIVE

The Fraud Abuse Executive (FAE) coordinates communication between HFS OIG and law enforcement entities and collaborates with the MCOs on data requests for criminal and civil investigations. FAE responds to law enforcement data requests and assists with the review and approval of global settlement agreements generated by the National Association of Attorneys General, HHS-OIG, and the Department of Justice. HFS OIG supports federal law enforcement and oversight counterparts including HHS-OIG, CMS, FBI, U.S. Attorney's Offices, and the National Association of Medicaid Fraud Control Units. FAE monitors law enforcement cases involving the Illinois Medicaid program and identifies key departmental staff members to provide expert-witness testimony at criminal and civil proceedings. Upon completion of the criminal or civil case, FAE assists with internal administrative actions as necessary. Administrative actions can include audit reviews, PRU reviews, and administrative sanctions, including payment suspensions, overpayment recoupments, and termination from the Illinois Medicaid program.

FY2024 FAE STATISTICS

Referrals to MFCU: 57
Accepted: 54
Not accepted: 3

Responses to Data Requests: 102
Law enforcement data requests: 65
Law enforcement information requests: 27
MCO data requests: 6
MCO information requests: 4

NEW PROVIDER VERIFICATION AND MONITORING

The New Provider Verification (NPV) Unit reviews new applications, application modifications, and revalidations for all high-risk Medicaid providers, including transportation, durable medical equipment (DME), pharmacy with DME, and home health providers, as well as providers of concern due to past convictions or sanctions. NPV reviews applicant information, such as background checks, licenses, insurance, and corporate records. Based on NPV's findings, OIG determines whether to grant or deny an applicant's enrollment.

NPV also monitors new providers that are designated as high risk for fraud (based on provider type) for one year after enrollment. Provider billing activities and claims are

analyzed several times during a provider's conditional enrollment, and the NPV analyst contacts the provider to offer guidance and answer questions they may have regarding serving as a Medicaid provider. If no concerns are identified after a year of monitoring, the provider becomes a fully enrolled Medicaid provider. If problems are identified, OIG may decide to extend the provider's conditional enrollment or to disenroll the provider.

FY2024 NPV HIGHLIGHTS

Development and implementation of virtual on-site inspections: Effective July 2023, NPV was tasked with developing and implementing a process for conducting on-site visits on a temporary basis for certain high-risk providers. Under new CMS guidance, states were provided the flexibility to complete site visits virtually using synchronous video technology. NPV successfully launched a virtual on-site process, first rolled out to transportation providers. In November 2023, this process was applied to the remaining high-risk providers (home health, DME, pharmacy with DME, and hospice) as well as moderate risk providers (ambulances and laboratories). In FY2024, 530 site visits for moderate and high-risk providers were completed.

Deterring fraud at the front end (Case Nos. 1404721 and 1414367): At a high-risk transportation provider's six-month follow up, NPV found that the transportation company was leasing a vehicle from a daycare provider. The daycare and transportation providers were under the same ownership and had significant overlapping operating hours. The owner of both companies was identified as being the only employee at both companies. This included the daycare duties and driving duties for the transportation company. After NPV inquired about how the provider could run both companies at the same time, the provider removed herself from the program as a transportation provider. NPV also determined the provider was enrolled as an IP to provide in-home services for DHS-DRS. These potential conflicts in service hours were referred to BOI for further investigation.

FY2024 NPV STATISTICS

Provider Enrollment Referrals Received: 1,715

- New applications opened: 795
- Modifications opened: 873
- Re-enrollments/reinstatements opened: 47

Applications Reviewed and Outcomes:[10] 1,733

- New applications
  - Approved: 704
  - Denied: 28
  - Withdrawn: 2
  - Returned to DRS/PES: 61

[10] Some applications reviewed in FY2024 were received in FY2023.

Modifications
- Approved: 839
- Denied: 1
- Withdrawn: 3
- Returned to PES: 32

Re-enrollments/Reinstatements/Revalidations
- Approved: 57
- Denied: 4
- Withdrawn: 2

Applications Pending: 53

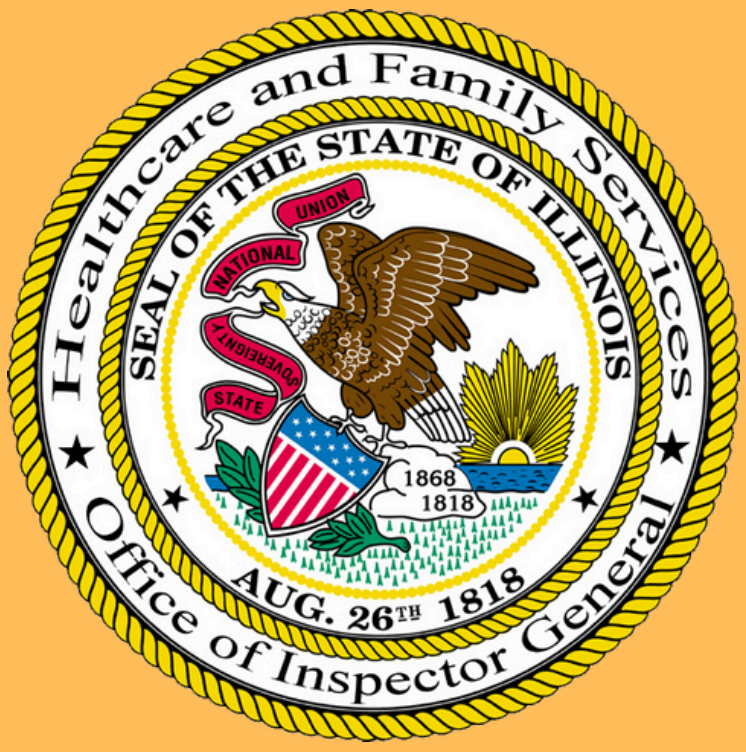
On-Site Reviews Performed: 530

Providers Monitored

Monitoring term ended: 105
- Enrolled: 85
- Disenrolled: 20

Providers under Monitoring at Close of FY2024: 232

Bureau of Internal Affairs



BUREAU OF INTERNAL AFFAIRS (BIA)

HFS OIG's Bureau of Internal Affairs (BIA) investigates allegations of misconduct by HFS and IDoA employees, contractors, and vendors. BIA gathers facts by interviewing witnesses and subjects, conducting surveillance, and reviewing documents. At the conclusion of BIA's investigative activities, BIA prepares a report with findings for the appropriate Department's division administrators. Until early 2024, BIA also held various security responsibilities for HFS, including monitoring the safety of employees and visitors in Department buildings; conducting background checks on new hires and staff who require access to Secretary of State data and/or federal tax information; granting and revoking facility access for employees and contractors; conducting wellness and fit-for-duty checks; and conducting threat assessments for the Department. Throughout the first few months of 2024, these responsibilities were transitioned to HFS's Department of Human Resources. The transition of these non-investigative responsibilities allows BIA to better focus on its mandate to investigate employee and contractor misconduct, including Medicaid providers.

FY2024 BIA HIGHLIGHTS

Child Support Services Employee Inappropriate Conduct Leads to Discharge (Case No. 1403236): In June 2023, BIA opened an investigation after receiving a referral from the HFS Office of Labor Relations alleging that a HFS Division of Child Support Services Specialist (DCSS) made sexual advances towards a Non-Custodial Parent (NCP) and gave the NCP money. After reviewing witness statements, BIA contacted the Illinois State Police (ISP). Once ISP completed their criminal investigation without charges, BIA proceeded with an administrative investigation. Based on the information from ISP's investigation, the employee's BIA interview and the forensic analysis of employee's State laptop, the preponderance of the evidence revealed that the employee violated numerous HFS policies by using the State laptop for personal use, smoking marijuana on State time, and creating a personal relationship with a child support customer. During his ISP and BIA interviews, the employee admitted that he exchanged personal telephone numbers with the NCP, gave the NCP money, and smoked marijuana with the NCP on State time. The employee also admitted to using the State laptop during work time for personal use to write and edit theatrical productions for which he received monetary compensation. As a result of the investigation, the DCSS was discharged.

Human Services Caseworker Consumption of Alcohol on Duty leads to Discharge (Case No. 1404526): In August 2023, BIA received a report alleging that a HFS Division of Medical Eligibility Human Services Caseworker (HSC) was in possession and under the influence of alcohol at the Bloom Building located in Springfield, Illinois. As a result of the report, BIA opened an investigation into the matter. BIA's investigation revealed that the HSC violated several HFS policies by possessing and drinking alcohol in an HFS facility while on duty. The employee knowingly brought a bottle of vodka into the Bloom Building and drank the vodka in an insulated cup mixed with soda. In his interview with BIA, the employee initially made false, inaccurate, or deliberately incomplete statements before finally

admitting to the conduct and apologizing for his actions. As a result of the investigation, the HSC was discharged.

Office Administrator Caught Accessing Personal Child Support Case (Case No. 1405180): In August 2023, BIA generated a Mobius Report Last Name Match Security Report (Security Report).[11] The Security Report reflected that a HFS DCSS Office Administrator IV accessed a case file of a client with the same last name as the employee. BIA opened an investigation and interviewed the office administrator. During the BIA interview, the office administrator acknowledged accessing her "old" child support case and apologized for doing so. Based on data from the database and the employee's statement that she accessed her own child support case, the evidence showed by a preponderance that the employee violated numerous HFS policies by accessing her own child support case. As a result of the investigation, the DCSS employee received a seven-day suspension.

Egregious Personal Computer Use Leads to Discharge (Case No. 1399330): In February 2023, BIA received a referral alleging that a DCSS Child Support Specialist I was using his State computer and State printers for personal use. The complaint further alleged that the employee used the internet on his State computer to search for photos of Casey Anthony and Jeffrey Dahmer and placed the photos in a co-worker's cubicle. BIA's investigation—which included a forensic review of the employee's State computer and the employee's own admissions—confirmed that the DCSS employee misused the internet, his State email, and other State equipment for personal use. BIA found that the employee used his State-issued computer to visit numerous non-work-related internet websites. BIA also found that the employee used his State email account for personal use. On at least two occasions the employee used a State scanning machine to copy and email non-work-related material. BIA also found that the employee's behavior, by placing pictures of Jeffrey Dahmer and Casey Anthony in a coworker's cubicle, was disruptive and inappropriate. BIA determined that the employee violated numerous HFS policies related to computer, email, and internet use. As a result of the investigation, the HFS employee was discharged.

Employee Misconduct Leads to Discharge (Case No. 1402759): In June 2023, BIA received a referral alleging a HFS Division of Medical Eligibility Human Services Caseworker engaged in inappropriate conversations while HFS clients were on the line. BIA reviewed recordings of eighteen HFS Medicaid All Kids hotline calls. The call evidence revealed that the employee did not notify customers before putting them on hold and, further, on at least some of these occasions the clients remained on the line. The callers were then able to hear the employee in conversation with his fiancée while using profane language, describing sexually explicit content and drug use, and making other inappropriate remarks. In his BIA interview, the employee admitted that it was his voice on the calls. He had no explanation for the calls and stated that he did not know they were being recorded. BIA's investigation found that the employee failed to follow HFS departmental policies

[11] The Security Report is a report BIA generates and reviews on a weekly basis. The Security Report identifies the name and Resource Access Control Facility identification number for all HFS Division of Child Support Services staff and contractors who access a child support case of someone with the same last name.

when he briefly answered phone calls and attempted to transfer them back to the phone queue to avoid speaking with clients. Moreover, the employee could also be heard speaking with his fiancée about a client's case during one of the recorded calls. As a result of the investigation, the HFS employee was discharged.

FY2024 BIA STATISTICS

Total Cases Opened

Misconduct investigations:	107
Background investigations:	492
Threat assessments:	16

Total Cases Completed

Misconduct investigations:	102
Background investigations:	492
Threat assessments:	16

Findings in Misconduct Investigations

Substantiated:	12
Unsubstantiated:	9
Administratively closed:[12]	26
Declined:	3
Referred:	52

Outcomes in Substantiated Investigations

Resignations/terminations:	8
Suspensions:	4

Average Case Length

Misconduct investigations:	17.1 Days
Background investigations:	1.7 Days
Threat assessments:	1.3 Days

Findings in Background Investigations

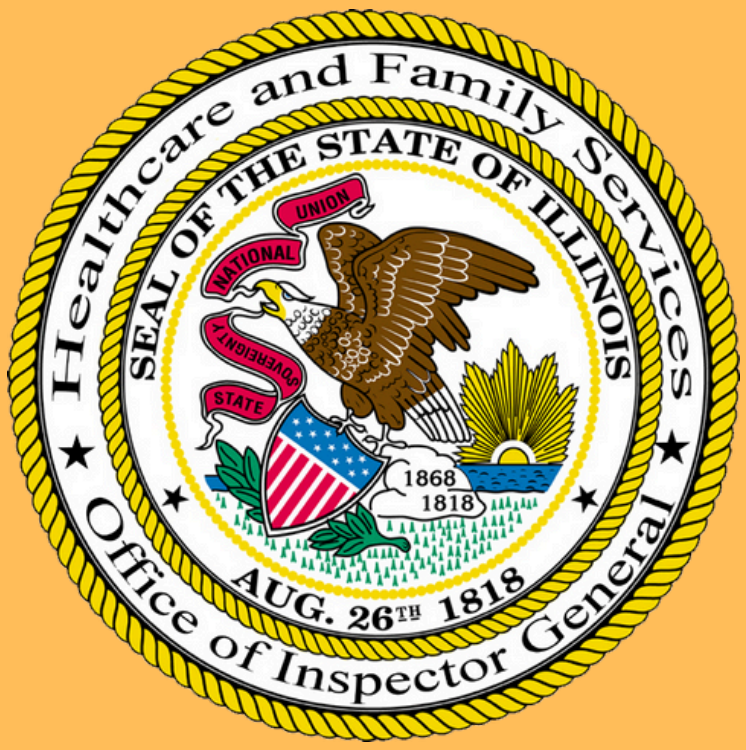
Candidates not hired:	13
Employees disciplined/resigned:	0

Security

Threat Assessments:	3
Facility Access/Badges Issues:	471

[12] A case is closed administratively when the matter is not within OIG's jurisdiction and is referred to the appropriate agency or department, or, in BIA's assessment, it has been or is being appropriately handled by another entity, the matter was consolidated with another investigation or, in rare circumstances, BIA determined that further action was unwarranted.

Office of Counsel to the Inspector General



OFFICE OF COUNSEL TO THE INSPECTOR GENERAL (OCIG)

HFS OIG attorneys in the Office of Counsel to the Inspector General (OCIG) have many responsibilities, including providing legal support to OIG bureaus, units, and internal committees; analyzing legislation that impacts OIG and HFS; administering OIG's responses to Freedom of Information Act (FOIA) requests and subpoenas; and coordinating with the HFS Office of General Counsel during external litigation matters. OCIG's primary responsibilities, however, lay with its representation of HFS before the department's administrative tribunal during actions brought against enrolled providers. Those actions generally take three forms: (1) actions by which HFS seeks to impose punitive sanctions on Medicaid providers that, the OIG determined, have engaged in fraud or misconduct; (2) actions by which HFS seeks to recover overpayments of Medicaid funds from providers, as identified by OIG or external auditors; and (3) actions taken to defend HFS's decisions to deny applications for enrollment or payment for services provided.

Any provider subject to an administrative action brought by OCIG is generally afforded the right to a hearing before the administrative tribunal to defend themself, and a provider's assertion of that right initiates what can be protracted litigation. On the other hand, a provider's failure to request a hearing or otherwise defend themself before the tribunal results in a default judgment in favor of HFS. Except where otherwise noted, litigation in each of the cases discussed below resulted in such default judgments, as ordered by the HFS Director through final administrative decisions.

FY2024 OCIG HIGHLIGHTS

OCIG Expands Its Enforcement Capability to Exclude Non-Enrolled Individuals from the Illinois Medicaid Program: The majority of OCIG's administrative actions seek to impose punitive sanctions against Medicaid providers who are determined to have engaged in fraud or misconduct. Although the sanction that OCIG pursues most often is the termination of a provider's enrollment, other types of sanctions may be imposed where circumstances warrant. One such available sanction is exclusion. Exclusion operates in a manner like termination and barrment in that it prevents individuals determined to have been involved in fraud or misconduct from participating in the Program. Exclusion also prevents sanctioned individuals from acting in certain capacities with respect to enrolled providers, such as members of enrolled providers' management groups or employees of enrolled providers.

Exclusion's reach is far broader than that of termination or barrment. The sanction may be imposed against individuals who are not enrolled as Medicaid providers, themselves, or otherwise members of a corporate providers' management group, but who nevertheless engaged in fraud or misconduct involving the Program's operations. As such, the sanction is generally imposed against (1) non-enrolled employees of enrolled corporate providers; or (2) individuals who had, at one point, participated in the Program either individually or through an enrolled provider, but later withdrew from the Program altogether.

The OIG generally did not pursue exclusion in years past. But, in FY2024, OCIG filed six administrative actions that sought to exclude non-enrolled individuals from the Program. Of those six actions filed, the HFS Director issued three final administrative decisions (with the remaining three pending), agreeing that the individual subjects should be excluded:

> ***In re Amanda Mirelez*** **(Case No. 1407461):** Amanda Mirelez is a former employee of Healthcare Plus Homemakers LLC, which is a privately owned Medicaid provider of in-home care. Healthcare Plus terminated Mirelez's employment after she had lied about providing care to Medicaid recipients, and for which she was wrongly paid $7,441 in Medicaid funds. The company reported Mirelez's fraud to the OIG and provided records substantiating the claim, which formed the basis for OCIG's action.
>
> ***In re Eric Giles*** **(Case No. 1404667) /** ***In re Woodley Dangerfield*** **(Case No. 1404668):** OCIG filed two separate exclusion actions against Eric Giles and Woodley Dangerfield, the former owners and corporate officers of medical-transportation company Arnetta's Right Way Transportation. Giles (the company's secretary and director) and Dangerfield (the owner and president) each directed the company's drivers to lie to field investigators from the HFS transportation broker about their qualifications to drive for a Medicaid-enrolled transportation provider. OCIG sought to exclude Giles and Dangerfield when Giles withdrew Arnetta's Right Way from the Program before any termination action could be taken against the company.

After a Full Evidentiary Hearing, OCIG Prevails to Secure the Repayment of Over $122,000 in Medicaid Funds: In FY2024, the HFS Director issued a final administrative decision in *In re Catch a Ride Transportation, Inc.* (Case Nos. 1150565, 1151235 & 1183677), concluding that OCIG had successfully proved that medical-transportation provider Catch a Ride Transportation had received $122,047 in undeserved Medicaid funds, stemming from the company's extensive submission of improper billing claims. Those overpayments were initially identified by OIG's Bureau of Medicaid Integrity, which performed three in-depth audits of the company. Specifically, the audits examined four-and-a-half years of records before identifying two categories of discrepant billing claims that the company submitted for payment: (1) duplicate billing claims submitted for the same services; and (2) billing claims that employed loaded mileage to inflate the distance that the company had transported passengers and, in turn, the amount the company would be paid by HFS.[13] Taken together, the audits calculated that, through the improper billing claims, Catch a Ride had wrongly received $122,047.

[13] Billing by using loaded mileage artificially inflates the miles driven by a medical-transportation provider when transporting more than one Medicaid recipient simultaneously. Instead of billing for the mileage of one trip, the provider will claim that the recipients were each transported that distance separately. For instance, a properly submitted claim for a ten-mile joint trip for recipients A and B will reflect only the ten miles driven. But if the provider were to bill by using loaded mileage, it would claim that recipients A and recipient B were each transported ten miles separately, resulting in a false total of 20 miles driven.

After Catch a Ride failed to repay the identified overpayments, OCIG took administrative action to enforce the audit results. Catch a Ride, in turn, asserted its right to challenge the audit before the administrative tribunal. After years of pre-hearing litigation, the HFS administrative tribunal held a four-day evidentiary hearing, where OCIG introduced extensive documentary evidence, including HFS billing records, and the testimony of several members of OIG and HFS staff, including: the BFST Bureau Chief; the OIG Fiscal Manager; a BMI audit supervisor; and the HFS Manager of Transportation Services. The testimony and documentary evidence detailed the audits' processes and explained how OIG reached the conclusion that Catch a Ride had utilized improper billing practices to receive larger Medicaid payments.

In October 2023, the administrative tribunal issued a 66-page recommended decision that handed a full victory to OCIG. Of note, the tribunal found that billing records introduced by OCIG were "replete with overpayments to [Catch a Ride] as a result of [its] submission of claims and improper duplicate billing," and further determined that the records unambiguously reflected that the company "had engaged in improper[] billing for loaded mileage." The tribunal therefore concluded that OCIG had shown by a preponderance of the evidence that HFS should be allowed to recover the overpayments in full.

The HFS Director agreed with the administrative tribunal. In a final administrative decision issued in November 2023, the Director adopted the tribunal's recommendation and ordered Catch a Ride to repay the full $122,047. Although Catch a Ride had the right to challenge the Director's final administrative decision before the Circuit Court of Cook County, it declined to do so, capping a very notable victory for HFS OIG, and the Department.

ACTIONS SEEKING PUNITIVE SANCTIONS CONCLUDED IN FY2024

Investigations undertaken by BOI and HFS OIG's investigative partners often uncover evidence that establishes that providers violated Illinois law and HFS regulations. In such cases, OIG is empowered to seek the imposition of punitive sanctions against individuals and corporate entities enrolled in the Illinois Medicaid Program as providers, including the termination of a providers' enrollment and, under certain instances, the barrment of appropriate personnel related to those providers from participating in the Program. As noted above, most administrative actions brought by OCIG seek the imposition of punitive sanctions. In FY2024, those actions fell into nine categories:

(1) Terminations of providers who billed the Program for services not rendered
(2) Terminations of medical professionals whose professional licenses to practice in Illinois were suspended, revoked, or otherwise terminated
(3) Terminations of providers who have criminal records that include disqualifying criminal convictions
(4) Terminations of providers who failed to satisfy debts owed to HFS

(5) Terminations of providers who were sanctioned by other state or federal healthcare programs
(6) Terminations for fraud or misconduct where recoveries of Medicaid funds were also appropriate
(7) Terminations of corporate providers where management-group members were previously sanctioned by healthcare programs or committed crimes
(8) Terminations of long-term or intermediate-care facilities when HHS, CMS, or IDPH, revokes certifications to operate
(9) Summary terminations of providers who breached corporate or settlement agreements, as well as providers whom the HHS excluded from Medicare or any other state healthcare program

Termination of Providers for Billing for Services Not Rendered

A significant portion of OCIG's termination actions focus on Medicaid providers who bill the Illinois Medicaid Program for services that they did not, in fact, perform. Although such actions are not limited to any one type of provider, a disproportionate number are those who provide personal-assistance care to homebound Medicaid recipients as part of the DHS Home Services Program or IDoA. Personal-assistance providers serve Medicaid recipients over the age of 60, or individuals with disabilities under age 60, who require help with daily living activities in their homes; many of these recipients are at risk of moving into nursing homes or other healthcare facilities. Because personal assistants serve a vulnerable population, OIG is particularly vigilant when identifying and investigating potential instances of personal assistants' fraud or misconduct, including billing fraud.

OIG and DHS often refer incidents of billing fraud to law enforcement for potential criminal prosecution. But in instances where law enforcement declines to prosecute, OCIG may initiate administrative action to terminate the offending providers' Medicaid enrollment. In FY2024, OCIG successfully sought such terminations in 27 matters where providers were found to have engaged in billing fraud. That fraud, in turn, resulted in providers fraudulently obtaining $340,118 in identified Medicaid-paid wages, which are now subject to recovery though additional legal action.

Although personal-assistance providers who engage in such billing fraud employ a variety of schemes, the patterns of misconduct generally fall into two categories. First, providers will purport to have rendered services at times when they were instead working elsewhere, or what is known as "secondary-employment fraud." Eighteen actions resolved in this fiscal year involved secondary-employment fraud, and notable examples include:

Case Name OIG Case Number	Period Over Which Fraud Occurred	Wages Fraudulently Obtained
In re Robinson Jusino (Case No. 1396347)	January 2018 – July 3 2022	$72,262
In re Nadia Levin (Case No. 1373664)	January 2019 – August 2021	$30,494
In re Alan Baureis (Case No. 1290448)	December 2014 – June 2017	$26,339
In re Angelique Jenkins (Case No. 1330923)	November 2015 – April 2019	$22,477
In re Ricardo Martinez (Case No. 1371399)	April 2019 – February 2020	$21,459

The second fraudulent scheme is known as "inpatient fraud," where providers bill for services that could not have been rendered because the recipients under their care were, in fact, hospitalized or residing in a long-term care or similar facility at the times of the claimed services. OCIG prevailed in five actions where evidence of inpatient fraud existed:

Case Name OIG Case Number	Period Over Which Fraud Occurred	Wages Fraudulently Obtained
In re Maya Erving (Case No. 1398678)	May 2021 – June 2022	$10,392
In the Matter of Felicia Hughes (Case No. 1343547)	March 2018 – October 2019	$8,038
In re Tyron Ward (Case No. 1375298)	April 2021 – May 2021	$3,275
In re Judy Harr (Case No. 1396353)	July 2019 August 2019 – November 2019	$2,916
In re Jeremy Legereit (Case No. 1341782)	April 2019 – May 2019	$1,117

In four additional cases, OCIG prevailed in actions involving fraudulent schemes that did not involve either secondary-employment or inpatient fraud:

In re Santila Terry **(Case No. 1165036):** Santila Terry, owner of occupational-therapy provider Special Therapy Care Services Chartered, submitted false billing claims for speech-therapy services that were purportedly provided by a former employee, but after that employee had, in fact, left the company. Through her scheme, Terry obtained $909,500 from managed-care organizations and government healthcare programs, including $379,248 from the Program.

In re Rene Salazar **(Case No. 1275980):** Personal assistant Rene Salazar fraudulently billed HFS for the supposed provision of $11,703 in services that he did not render because he was serving a prison sentence at Vienna Correctional Center on the dates of the claimed services.

In re Amelia Rayford **(Case No. 1288468):** Amelia Rayford, a personal assistant, lied when claiming that she had provided services to an Illinois-based Medicaid recipient when she was, in fact, physically present in Tennessee. Rayford was paid $9,677 for services that she did not provide.

In re Lori Spivey **(Case No 1289578):** Lori Spivey claimed to have rendered $2,231 in personal-assistance services to a Medicaid recipient for whom she no longer worked because the recipient had previously asked to remove her as a caretaker.

Terminations Resulting from Professional Sanctions

The Illinois Department of Financial and Professional Regulation (IDFPR) is the State of Illinois's agency that regulates the medical profession by, among other things, ensuring that competent professionals are properly licensed to provide services to the public. In its role, IDFPR has the authority to revoke, suspend, terminate, or otherwise sanction medical professionals' licenses to practice in Illinois when those professionals engage in misconduct, or otherwise fall below the minimum threshold for acceptable standards of care. When IDFPR sanctions Medicaid providers, OIG may take action to terminate those providers' enrollment in the Illinois Medicaid Program. In FY2024, OCIG successfully sought the termination of 26 Medicaid providers upon the imposition of IDFPR sanctions. The matters involving the most severe provider misconduct are identified below:

Matter Name OIG Case Number	Reasons for Underlying IDFPR Sanction
In re Narayanarao Ravishankar, MD (Case No. 1327807)	Engaging in dishonorable and immoral conduct against patients, specifically, sexual assault
In re Hiralal Maheshwari, MD (Case No. 1408503)	Being convicted of criminal battery against patient during course of treatment

In re Syed Warsi, MD (Case No. 1390212)	Engaging in improper prescribing practices of Xanax, Tramadol, Klonopin, Soma, amphetamine-based products, and hydrocodone-based products
In re John Newlin, MD (Case No. 1401499)	Engaging in improper prescribing practices of various controlled substances to several patients of his private practice
In re Steven Lobacz, MD (Case No. 1398394)	Engaging in improper prescribing practices of controlled substances to several patients that led to the surrender of prescribing license

Terminations Based on Criminal Convictions

HFS regulations allow for the termination of providers' enrollment in the Illinois Medicaid Program where they "engaged in practices prohibited by applicable federal or State law or regulation." In addition, Medicaid providers' enrollment can be terminated if they have been convicted in state or federal court of certain disqualifying offenses.[14]

In FY2024, OCIG prevailed in 23 actions that were based on providers' convictions of criminal offenses. Each of those convictions were based on various types of fraud, including the kinds of billing fraud — secondary-employment and inpatient fraud — discussed earlier. Notable examples follow.

> ***In re Michael Egan*** **(Case No. 1406174):** Dentist Michael Egan was convicted in the U.S. District Court for the Northern District of Illinois of wire fraud in connection with a scheme to defraud a financial institution, The Lending Club. He was sentenced to serve 30 months of imprisonment and ordered to pay $1,200,000 in restitution to the institution.
>
> ***In re John Greager*** **(Case No. 1399212):** Physician John Greager was charged in the U.S. District Court for the Northern District of Illinois with one count of healthcare fraud after submitting approximately $4.1 million in fraudulent billing claims to healthcare programs. Dr. Greager subsequently pleaded guilty to the crime; he was sentenced to serve six months imprisonment and ordered to pay total restitution of $1,745,779 to BlueCross BlueShield of Illinois, the U.S. Office of Personnel Management, and the U.S. Department for Health and Human Services.

[14] These offenses include murder; class X felonies under the Illinois Criminal Code; sexual misconduct that may subject Medicaid recipients to an undue risk of harm; criminal offenses that may subject Medicaid recipients to an undue risk of harm; crimes of fraud or dishonesty; crimes involving controlled substances; misdemeanors relating to fraud, theft, embezzlement, or breaches of fiduciary responsibilities; crimes of fraud or willful misrepresentation related to healthcare programs, including the Illinois Medicaid Program, or the provision of healthcare services; other crimes of financial misconduct related to healthcare programs, also including the Illinois Medicaid Program.

In re Linus Anukwu, MD **(Case No. 1245820):** Physician Linus Anukwu was indicted in the U.S. District Court for the Central District of Illinois on eight counts of various healthcare-related crimes related to his scheme to defraud healthcare programs related to his treatment of opioid-addicted patients. Anukwu pleaded guilty to one count of making false statements related to healthcare matters. He was sentenced to serve three months of imprisonment and six months of supervised release and ordered to pay $200,002 in restitution to the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, and several managed-care organizations.

In re Marcella Bones **(Case No. 1348519):** Personal Assistant Marcella Bones was convicted in the Circuit Court of Cook County of one count of felony vendor fraud and receiving or providing kickbacks related to her commission of inpatient fraud. Through that fraud, Bones illegally received $30,995; at sentencing, she was ordered to pay $21,219 of that amount to DHS, serve four years of probation, and perform 50 hours of community service.

In re Howard F. Jackson, DPM **(Case No. 1330019):** Podiatrist Howard Jackson was convicted in the U.S. District Court for the Southern District of Illinois of one count of felony healthcare fraud after he had billed the Program for nail avulsion procedures that he did not provide. He was ordered to repay the $28,763 that he obtained through the fraud to HFS (along with restitution to CMS totaling $115,931) and serve three years of probation.

In re Janice Miller **(Case No. 1373044):** Janice Miller, a personal assistant, engaged in inpatient fraud; as a result, she received $21,166 in ill-gotten Medicaid funds. She was subsequently convicted in the Circuit Court of Cook County of one count of felony theft. Miller was sentenced to serve four years of probation and ordered to perform 30 hours of community service and pay $20,434 to DHS.

Terminations for Failures to Repay Debts to HFS

Providers enrolled in the Illinois Medicaid Program can incur debts to HFS in several ways, such as through final administrative decisions ordering them to repay money to the department or by the terms of settlement agreements. In those instances where providers are delinquent in repaying debts, OCIG can take action to terminate their Medicaid enrollment. Where corporate entities are the delinquent debtors, OCIG can take additional action to bar members of those entities' management groups from participating in the Program.

In FY2024, OCIG prevailed in eight actions seeking the terminations of corporate providers that owed HFS a total of $597,261, along with the barrment of management-group members, where appropriate. Four notable actions are summarized in the following table.

Matter Name OIG Case Number	Unresolved Debt Amount and Administrative Actions Taken
In re Elfman Pharmacy, Inc. (Case No. 1166104)	○ $480,859 debt established by final administrative decision enforcing audit findings ○ Enrollment of provider Elfman Pharmacy terminated ○ Owner Arnold Einbinder barred from participating in the Program further
In re MHC d/b/a LaSalle Healthcare Center (Case Nos. 1120522 & 1351921)	○ $49,599 debt established by final administrative decision enforcing audit findings ○ Enrollment of MHC terminated ○ Owner Harry Grunstein barred from participating in the Program further
In re Glo's Medivac Transportation (Case No. 1351930)	○ $19,776 debt established by final administrative decision enforcing audit findings ○ Enrollment of provider Glo's Medivac Transportation terminated ○ Owner Gloria Howard barred from participating in the Program further
In re Robert Hampton d/b/a Come Back Transportation (Case No. 1151363)	○ $17,448 debt established by final administrative decision enforcing audit findings ○ Enrollment of provider Come Back Transportation terminated ○ Owners Robert and Everlene Hampton barred from participating in the Program further

Terminations of Providers Who Were Sanctioned by Other State or Federal Healthcare Programs

Federal law mandates that HFS must terminate providers' enrollment in the Illinois Medicaid Program when those providers are terminated from, or otherwise sanctioned by, other states' Medicaid programs or other federal healthcare programs. In eleven matters, OCIG successfully sought the termination of providers' Medicaid enrollment based on information provided by CMS. Samples of those cases follow.

Matter Name OIG Case Number	Sanctioning Agency and Program(s)
In re Smitha Sadiq (Case No. 1398640)	○ Maryland Department of Public Health (Medicaid) ○ Vermont Department of Health Access (Medicaid) ○ Alabama Medicaid Agency (Medicaid) ○ Arizona Health Care Cost Containment System Office of Inspector General (Medicaid)

In re Jolly Nurse Practitioner d/b/a Prime Care Physicians (Case No. 1404477)	CMS (Medicare)
In re Shopko Optical (Case No. 1393027)	Nebraska Department of Health and Human Services (Medicaid)
In re Shopko Pharmacy (Case No. 1393018)	Iowa Department of Health and Human Services (Medicaid)
In re Gateway Health Systems (Case No. 1279919)	CMS (Medicare and Medicaid)
In re Sunil Chand (Case No. 1402039)	Missouri Department of Social Services (Medicaid)

Terminations for Fraud or Misconduct Where Recoveries of Medicaid Funds Were Also Appropriate

In certain instances, OCIG can simultaneously seek to impose punitive sanctions on Medicaid providers who engaged in fraud or misconduct and recover the resulting Medicaid funds. In FY2024, OCIG obtained final administrative decisions in two such cases, terminating corporate providers and barring their owners, and recovering a total of $693,079.

In re BWR Transportation Inc. **(Case No. 1382798):** In February 2022, HFS deactivated medical-transportation company BWR Transportation Inc. as a Medicaid provider because its owner, Melvin Beauchamp, Jr., failed to update the registration information for the company's vehicles, and show that he had renewed his Illinois driver's license after it had expired. Beauchamp eventually submitted the required information but, upon examination, OIG concluded that (1) Beauchamp had never renewed his driver's license; (2) BWR had billed for providing transportation services throughout the time that Beauchamp's had an out-of-date driver's license; and (3) BWR was, in fact, paid a total of $692,410 for those services. OCIG successfully sought the termination of BWR's enrollment, barrment of Beauchamp from participating in the Program, and recovery of $692,410 that was paid to the company while it was out of compliance with Program requirements.

In re Alpha and Omega Transit Networks Inc. **(Case No. 1330423):** An OIG audit of medical-transportation provider Alpha and Omega Transit Networks Inc. concluded that the company had received $669 in overpayments of Medicaid funds stemming from various improper billing practices. However, the company did not cooperate with the audit, repay the identified overpayments, or otherwise respond to the audit findings. Based on Alpha and Omega's failure to cooperate, OCIG successfully obtained the termination of its enrollment, barrment of its owners, Charles Doty and Cynthia Cherry, from participating in the Program, and recovery of $669 in overpayments.

Terminations of Corporate Providers Where Management-Group Members Were Sanctioned by a Healthcare Program or Engaged in Illegal Acts

Under Illinois law, certain bad acts of an enrolled corporate provider's management group — its owners, corporate officers, investors, and managing employees — are imputed to the corporate provider itself. Specifically, a provider's enrollment may be terminated where members of its management group (1) were previously terminated, suspended, excluded, or barred from the Illinois Medicaid Program or another state or federal healthcare program; or (2) engaged in practices prohibited by state or federal law. In four actions, OCIG successfully argued that the enrollment of corporate providers should be terminated based on the bad acts of its management group:

Matter Name OIG Case Number	Underlying Bad Acts of Provider's Management Group
In re Behavioral Health Care Associates (Case No. 1395588)	Medicaid enrollment of managing employee and corporate officer, Blaise Wolfrum, previously terminated based on IDFPR sanction
In re Heartland Emergency Specialists (Case No. 1401721)	Medicaid enrollment of managing employee and corporate officer, Richard Sabbun, previously terminated based on IDFPR sanction
In re HFE 78 Inc. (Case No. 1402786)	Owner Tammy Dobbin convicted in federal court of bank fraud
In re MidPoint Home Care Inc. (Case No. 1403514)	○ Owner Felix Omorogbe convicted in federal court of money laundering ○ Owner Patricia Omorogbe convicted in federal court of engaging in a conspiracy to commit healthcare fraud

Terminations of Facilities upon CMS or IDPH Decertification

Although not common, the HFS Bureau of Long-Term Care will notify OCIG that either CMS or IDPH determined that a long-term or intermediate-care facility is out of substantial compliance with federal regulations that govern Medicare and Medicaid programs' participation requirements. In either case, the facility is afforded several opportunities to return to compliance, but if it does not, CMS or IDPH will terminate the provider agreement with the facility. OCIG, in turn, will file an administrative action to terminate the facility's provider agreement with HFS.

Although OCIG was notified of four long-term or immediate-care facilities scheduled for decertification by CMS or IDPH in FY2024, each of the four returned to substantial compliance with regulations before decertification. Consequently, OCIG filed no actions this

fiscal year that sought the decertification of long-term or immediate-care facilities. Similarly, no decertification matters were resolved through a final administrative decision.

Summary Termination and HHS-Mandated Exclusion Actions

As noted earlier, providers subject to administrative actions are generally afforded the right to an administrative hearing. There are, however, limited circumstances in which a provider's enrollment may be terminated without first necessitating a hearing. One such instance is when a provider breaches a corporate integrity agreement (CIA). A CIA is an agreement into which the provider will enter in lieu of termination where grounds for termination exist. The terms of a CIA generally require the provider to repay any overpayments of Medicaid funds that OIG identifies, undertake corrective actions to address acknowledged improprieties or shortcomings, and provide OIG with regular reports detailing the results of those corrective actions. By entering into a CIA, the provider also (1) agrees that its enrollment may be summarily terminated should it fail to meet any requirement outlined in the agreement; and (2) waives its right to an administrative hearing to challenge that termination.

In FY2024, no provider was terminated for its breach of a CIA. Coming into this fiscal year, OCIG continued to monitor four CIAs that carried over from FY2023; the effective period of three of those four agreements expired during FY2024 without necessitating further action. OCIG also entered into one new CIA during the year. As a result, OCIG will continue to monitor two CIAs through FY2024 into at least FY2025.[15]

In addition, OIG may summarily terminate the enrollment of a provider upon the breach of a payment agreement or settlement agreement that includes provisions allowing for immediate termination upon the agreement's breach. Where appropriate, OIG may also bar members of a corporate providers' management group from participating in the Program further. This fiscal year, three providers were terminated, and the owners of two of those providers were barred, after the providers had breached such agreements.

OIG also immediately terminates the enrollment of any provider that the U.S. Department of Health and Human Services excludes from the Medicare program or any other state healthcare program. In FY2024, OIG imposed summary exclusions of this type in nine matters.

ADMINISTRATIVE APPEALS CONCLUDED IN FY2024

OCIG defends administrative appeals taken by (1) applicants to become enrolled providers in the Illinois Medicaid Program whose applications were denied; and (2) medical-transportation providers to challenge HFS's denials of payment for services. OCIG's efforts regarding those appeals are detailed below.

[15] Confidential investigations, audits, and reviews continue while OIG monitors CIAs. Therefore, the matters underlying CIAs will not be detailed. Similarly, the matters that underlie CIAs that have expired will not be detailed because, in those instances, no punitive action was taken against the providers.

Defense of Denials of Applications for Enrollment

Providers must apply to become enrolled Medicaid providers, and applications may be denied where the applicant is found to have engaged in activities that would constitute grounds for an otherwise-enrolled provider's termination from the Program. When an application to enroll is denied, the applicant has the right to appeal the determination to the HFS administrative tribunal. In such cases, OCIG represents HFS to defend the decision. In FY2024, OCIG successfully defended the denial of applications in four matters:

Matter Name OIG Case Number	Reason for Application Denial
In re Redacted (Case No. 1399719)	Previous conviction for a crime of sexual misconduct that may subject Medicaid recipients to an undue risk of harm, specifically, one count of felony aggravated criminal sexual abuse with a child
In re Redacted (Case No. 1404874)	Previous conviction for a crime of sexual misconduct that may subject Medicaid recipients to an undue risk of harm, specifically, one count of felony aggravated criminal sexual abuse with a victim who was under 13 years of age
In re Redacted (Case No. 1406087)	Previous conviction for a crime of violence and sexual misconduct that may subject Medicaid recipients to an undue risk of harm, specifically, one count of felony aggravated trafficking in persons
In re Redacted (Case No. 1406252)	Previous conviction for a crime of violence that may subject Medicaid recipients to an undue risk of harm, specifically, two counts of felony aggregated battery with a firearm

Defense of Denial of Payment for Medical Transportation

Medical-transportation providers' administrative appeals of decisions to deny payment for transportation services were placed on hold from 2019 to late 2022 in response to legislation that resolved providers' challenges outside of the appeals process. Relying on that legislation, in FY2023 OCIG attorneys successfully worked with attorneys for transportation providers to dismiss nearly 1,200 unadjudicated appeals. These efforts continued throughout FY2024, with an additional 15 appeals being dismissed. OCIG continues to work with providers' counsel and the HFS administrative tribunal to resolve appeals scheduled to be dismissed.

Appeals have resumed now that the effective period of the legislation has passed, and OCIG has worked to ensure that the matters are promptly addressed. Notably, OCIG engaged the Bureau of Professional and Ancillary Services at HFS to institute a revised payment-review

process intended to preempt the involvement of the administrative tribunal. This revised process has resulted in determinations authorizing payments in 73 of the 113 appeals filed since 2022. In addition, the revised review process helped to decrease the number of appeal filings in FY2024 from hundreds in years past to only ten, further ensuring that the bureau's and the administrative tribunals' resources are put to their best use.

FY2024 FINANCIAL RECOVERY ACTIONS

Illinois law charges OIG with the recovery of overpayments of Medicaid funds identified by audits performed by BMI, as illustrated by OIG's victory in *In re Catch a Ride*. OIG is further authorized to recover Medicaid funds identified by audits performed by OIG's external Recovery Audit Contractor (RAC), CMS's Unified Public Integrity Contractor (UPIC), or private accounting firms retained by the OIG.

Including the recovery of $122,047 in *In re Catch a Ride*, OCIG attorneys obtained final administrative decisions in recovery actions where the HFS Director determined that HFS is allowed to recover a total of $305,390 in overpayments. In addition, OCIG collected $144,651 from providers who opted to remit full audit amounts before administrative actions concluded. As a result, OCIG secured the repayment of $450,041 in total.[16]

Audits Completed by BMI

In FY2024, OCIG successfully advanced eight cases enforcing audits completed by BMI — including *In re Catch a Ride* — yielding a total of $354,535 in monetary awards for HFS. In three cases in addition to *In re Catch a Ride*, OCIG obtained favorable judgments through which providers were ordered to repay a total amount of $171,249:

> ***In re Monroe Pavilion Health & Treatment Center*** **(Case No. 1280051):** A BMI audit of long-term care facility Monroe Pavilion Health & Treatment Center found 84 discrepancies in 305 resident accounts for the audit period of July 2015 through December 2016, and which resulted in the facility receiving $87,592 in overpayments.
>
> ***In re Lincoln Yellow Cab*** **(Case No. 1168094):** After auditing medical-transportation provider Lincoln Yellow Cab, BMI determined that, between July 2010 through December 2012, the company had submitted billing claims related to 355 Medicaid recipients that contained 237 discrepancies, resulting in $72,290 in overpayments of Medicaid funds.
>
> ***In re Hill's Transportation*** **(Case No. 1308747):** Here, BMI examined billing records submitted by medical-transportation provider Hill's Transportation from January 2014 through September 2017, and determined that the company had failed

[16] This amount is in addition to the favorable decisions obtained in the administrative actions discussed above where OCIG successfully sought both the termination of providers' enrollment and recovery of a total of $693,079 in Medicaid funds.

to support 92% of paid services with proper documentation. As a result, BMI concluded, Hill's had received $11,367 in overpayments.

In four additional matters, and after OCIG initiated recovery actions, the providers opted to repay the identified overpayments in full instead of proceeding to hearing. In all, the providers remitted $61,239.

Audits Completed by the RAC and UPIC

In FY2024, OCIG obtained a total of $80,217 in overpayments through RAC audits. Two RAC matters were resolved through the administrative-hearing process, where the administrative tribunal concluded that HFS was entitled to recover $12,094 in total Medicaid funds. Both cases involved billing claims that were not supported by DRG validation:

> ***In re Mercy Hospital Medical Center*** **(Case No. 1337749):** HMS concluded that HFS issued a $7,709 overpayment to Mercy Hospital Medical Center for the unsupported treatment of a patient's severe protein and calorie malnutrition.
>
> ***In re Galesburg Hospital Corporation*** **(Case No. 1398869):** HMS found that one billing claim that Galesburg Hospital had submitted for treating a patient for septic shock was unsupported. That claim, HMS determined, resulted in an overpayment of $4,385.

In addition, in three matters, providers remitted payment to satisfy identified overpayments before the issuance of any final administrative decision; those payments totaled $68,123.

In FY2024, no recovery action based on a UPIC audit resulted in a final administrative decision. In one action, though, the provider paid the full overpayment amount identified by a UPIC audit, $15,289, before the conclusion of administrative proceedings.

WITHHOLDINGS OF MEDICAID PAYMENTS IN FY2024

Under certain circumstances, OIG is authorized to direct HFS and MCOs to withhold all Medicaid payments to be paid to a provider for services rendered before any administrative action is taken against the provider:

- When a provider, or a member of a corporate provider's management group, has been indicted or charged with a crime that is based on alleged fraud or willful misrepresentation related to (1) the Illinois Medicaid Program; (2) another state or federal healthcare program; or (3) the provision of healthcare services.
- When OIG receives from a law enforcement agency, from a federal oversight agency, or through the results of a preliminary OIG audit, credible evidence that a provider, or a member of a corporate provider's management group, engaged in fraud or willful misrepresentation related to the Program.

- Upon the initiation of an audit of a provider, a quality-of-care review of a provider, or an investigation in which there are credible allegations of fraud on the part of a provider or a member of a corporate provider's management group.
- When a provider, or a member of a corporate provider's management group, demonstrates a clear failure to cooperate with HFS.

OCIG attorneys review allegations and evidence before recommending that the imposition of a payment withhold is appropriate. Attorneys also work with OIG's Fraud Abuse Executive to coordinate the imposition of any withhold with state and federal law-enforcement agencies, outside oversight agencies, and MCOs. In FY2024, OIG directed HFS to impose 14 payment withholds.[17]

FY2024 SETTLEMENT AGREEMENTS

As part of OIG's ongoing effort to ensure that HFS resources are preserved, including HFS's time and money, OCIG is empowered to negotiate settlement agreements to bring matters to a quick resolution. In FY2024, OCIG attorneys successfully negotiated a total $992,292 in settlements in the below five matters:

Settlement of $307,795 in Recovery Action Brought Against Long-Term Care Facility (Case No. 1262771): An auditor retained by HFS OIG reviewed a long-term care facility's resident accounts and concluded that it had received $512,992 in overpayments of Medicaid funds. OCIG filed an administrative action to recover the funds, but the facility subsequently agreed to resolve the matter by paying $307,795.

Settlement of $277,787 with Long-Term Care Facility (Case Nos. 1119593, 1096938, 1096939, 1119598, 1110984, 1121682, 1121678, 1294833 & 1141829): In 2010 and 2013, BMI conducted separate audits of several long-term care facilities owned by one umbrella corporation and determined that the facilities had received a total of $953,000 of Medicaid funds for services that did not meet Medicaid requirements. HFS and the facilities executed a global settlement agreement in 2019, by which the facilities agreed to repay $500,000; the facilities, though, repaid only $75,000. The facilities were subsequently sold to a new umbrella corporation. In 2023, representatives of the owner of the original umbrella corporation contacted OCIG on their own accord to express the wish to repay as much of the remaining $425,000 debt as possible. To that end, the original owner offered to resolve the outstanding debt through one $277,787 lump-sum payment. Given the age of the audits at issue and the unique nature of the original owner's intentions, OCIG agreed to the offer.

[17] Confidential investigations and audits continue after the imposition of payment withholds. Therefore, the matters in which payment withholds were imposed, and the legal basis for those payment withholds, will not be detailed in this report.

Settlement of $177,650 with Long-Term Care Facility (Case No. 1344764): After conducting an audit of a long-term care facility, BMI concluded that the facility's resident accounts incorrectly included credit balances that resulted in $209,306 in Medicaid overpayments. The facility engaged OCIG to begin settlement negotiations before OCIG filed an administrative recovery action. Those negotiations yielded a settlement agreement, by which the facility agreed to repay $177,650.

Settlement of $175,000 in Termination and Recovery Action Brought Against Clinical Laboratory (Case No. 1289158): After conducting an audit of a clinical-laboratory facility, UPIC identified discrepant billing claims that the facility had submitted for payment, and which resulted in the payment of $230,144 of Medicaid funds to the laboratory. OCIG filed an administrative action in response, seeking to recover the overpayments, as well as the termination of the facility's Medicaid enrollment due to, among other things, its submission of false billing claims for services that it had not rendered. To resolve the matter, the laboratory agreed to repay $175,000 of the identified overpayments, and further agreed that its failure to pay the entire amount, or otherwise comply with the terms of the settlement, would result in the immediate termination of its Medicaid enrollment.

Settlement of $54,060 with Medical-Transportation Provider (Case Nos. 1236672 & 1283883): BMI audited a medical-transportation provider and concluded that the company had received a total of $54,060 in Medicaid overpayments stemming from improper billing claims that reflected nearly 12,000 billing discrepancies. Before OCIG filed an administrative action to terminate the company's enrollment and recover the identified overpayments, the company agreed to repay the entire $54,060. The company further agreed that its failure to pay the entire amount, or otherwise comply with the terms of the settlement, would result in the immediate termination of its Medicaid enrollment.

FY2024 OCIG STATISTICS

Total Administrative Actions Initiated: 154

- Termination Actions: 102
  - Actions seeking owner barrment: 9
- Exclusion Actions: 6
- Summary Terminations and Exclusions from Medicaid: 9
  - Terminations based on violations of settlement or payment agreements: 3
  - Exclusions mandated by HHS: 6
- Defense on Appeal: 9
  - Denials of enrollment applications: 9
- Recovery of Overpayments: 28
  - OIG audit recoupments: 19
  - RAC audit recoupments: 8
  - UPIC audit recoupments: 1

Final Actions: 139

- Termination Decisions: 105
  - Actions seeking owner barrment: 12
- Terminations Where Recovery Was Also Appropriate: 2
- Exclusion Decisions: 3
- Summary Terminations and Exclusions from Medicaid: 12
  - Terminations based on violations of settlement or payment agreements: 3
  - Exclusions mandated by HHS: 9
- Defenses on Appeal: 4
  - Denials of enrollment applications: 4
- Recovery of Overpayments: 8
  - OIG audit recoupments: 5
  - RAC audit recoupments: 2
  - UPIC audit recoupments: 1
- Matters Resolved by Settlement Agreement: 5

Payment Withholds: 14

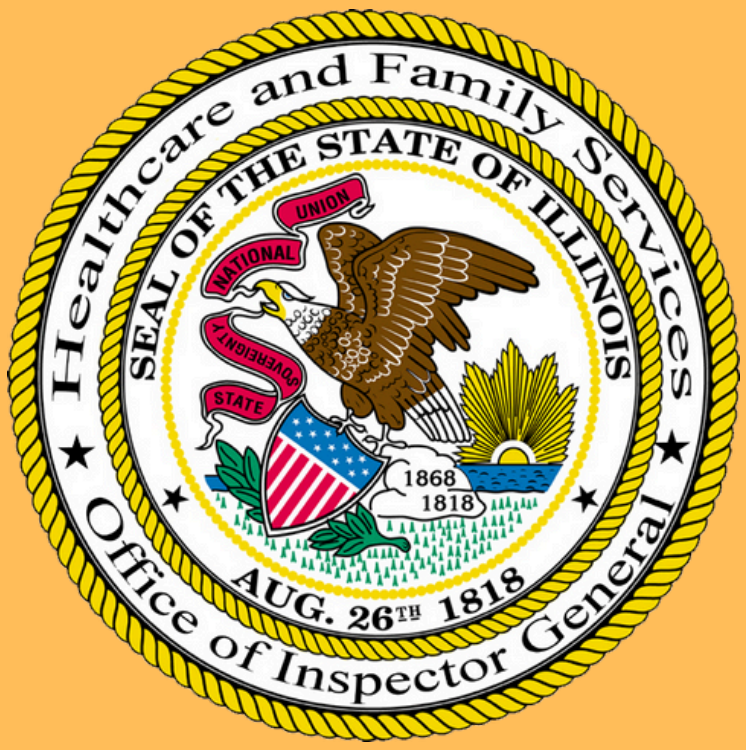
Corporate Integrity Agreements

- Ongoing at start of FY2024: 4
- Newly entered during FY2024: 1
- Total monitored: 5
- Total closed: 3
- Ongoing at end of FY2024: 2

Financial Impact: $2,135,412

- Overpayments Established by Final Administrative Decision: $1,143,120
- Overpayments Established by Settlements: $992,292
- Overpayments Repaid After Filing Notice: $144,651

Bureau of Fraud Science and Technology



BUREAU OF FRAUD SCIENCE AND TECHNOLOGY (BFST)

FRAUD SCIENCE TEAM and TECHNOLOGY MANAGEMENT UNIT

BFST is composed of the Fraud Science Team (FST), Technology Management Unit (TMU), and the Provider and Recipient Analysis Units (PAU/RAU). FST and TMU develop fraud-detection routines to prevent and detect healthcare fraud, abuse, overpayments, and billing errors, and manage OIG's supporting IT infrastructure. FST oversees the development and maintenance of the Dynamic Network Analysis (DNA) system. DNA routines are analytical computer programs written in Statistical Analysis System (SAS) and Teradata SQL utilizing HFS's Data Warehouse along with other third-party data sources.

FY2024 FST/TMU HIGHLIGHTS

Public Assistance Reporting Information System (PARIS) Analysis: In FY20204, BFST conducted an analysis based on the PARIS match results. PARIS is a tool managed by the Administration for Children and Families for use by states to support program integrity in public and medical assistance initiatives. PARIS includes interstate, VA, and federal matches. Records from the Illinois Integrated Eligibility System (IES) are extracted for PARIS submissions. Interstate data contains welfare programs that include Medicaid, TANF, SNAP, Worker's Compensation, and Childcare. BFST used the last few years of Medicaid records in its analysis to see if Illinois recipients received duplicate benefits in any other states during the same period. The number of services and capitation payments were calculated for overlapping days between Illinois Medicaid eligibility and those of other states. Death information from IDPH and IES were added to the analysis. Based on matching results, OIG contacted a few states to determine if other states with overlapping eligibility also made payments during the relevant time frame. This project is ongoing.

Prescription Monitoring Program Drug Utilization Review Report: BFST extracted claims from the Illinois Prescription Monitoring Program (ILPMP) datasets and corresponding population from the Enterprise Data Warehouse (EDW) to assist fulfillment of CMS annual reporting on the Medicaid Drug Utilization Review program. Tables and indicators were created, including detailed use data for opioids, stimulant ADHD medications, and sedative benzodiazepines for various age groups and populations of two or more controlled drugs. Average daily morphine milligram equivalent was calculated for fee-for-service and MCO populations. This report underscores ILPMP's role in monitoring Schedule II-V controlled substances by identifying trends and patterns across demographic segments.

HFPP Dental Study Assessment: BFST conducted a study to replicate findings from a Healthcare Fraud Prevention Partnership study. In October 2023, HFPP released a dental study outcome for excessive use of high-level dental codes. The study focused on services such as extractions, resin-based composite restorations, scaling, and root planning, identifying dentists who submitted claims with the highest complexity codes that exceeded data-driven thresholds. After reviewing the detailed study methodology and logic, the DNA team extracted

all related dental claims from the EDW and performed similar analysis for a broader time range. The HFPP study was performed on the dental claims from the Transformed Medicaid Statistical Information System (T-MSIS), a subset of claims compared to the complete EDW. Using the same study period, BFST identified a discrepancy of over $1.2 million between T-MSIS and EDW data. BFST recommended sampling each audit scenario and conducting a probe audit at the recipient level to verify the legitimacy of any identified excessive service utilization.

Medical Transportation Management, Inc. (MTM) Mileage Reimbursement Analysis: In FY2024, BFST supported BOI in its investigation of dozens of private auto transportation providers who submitted fraudulent reimbursements through a mobile application offered by MTM, Inc., a transportation broker contracted by several MCOs to schedule transportation and process claims. After receiving dozens of fraud referrals in mileage abuse cases, OIG requested MTM submit its relevant Medicaid claim data for a comprehensive scheme analysis. BFST aggregated the service data by individual members and billing providers, helping to prioritize the most significant outliers for further criminal and administrative investigation.

Improvements and Efficiencies in DNA Reports: BFST developed and improved several DNA reports that will drive efficiencies in OIG operations. These include:

LTC Audit Report: BFST migrated this report Power BI queries to the DNA site allowing auditors to gather all relevant information through a single submission with one resultant file which includes the needed client list by audit period, deceased clients, client third-party liability history, credit balance, payment history, and bed reserve capacity information. This process streamlines report generation and reduces potential errors associated with manual data handling.

Administrative Support Unit (ASU) Reports: BFST created ASU reports for use in monitoring and validating payment collections and adjustments. ASU staff have different various report options including adjustment inquiry, claim collected inquiry, payment agreement number inquiry, provider claim detail inquiry, provider ID check, payment by month, and provider summary. ASU is now able to query by multiple document control numbers improving search efficiency and allowing quick access to recoupment information.

DNA Architecture Enhancement: BFST made steady progress on front-end development and backend infrastructure with a focus on security in preparation for the next DNA release. BFST improved user management functionality with the notable addition of Teradata user account configuration to the web interface. This new feature provides a clear view on the working schemas and temporary space, allowing administrators to quickly identify the scope and nature of SAS module issues, reducing troubleshooting time. Lightweight Directory Access Protocol (LDAP) integration was successfully implemented, and relevant programs were rewritten to adapt LDAP support. This addition enhances the DNA user experience by allowing for seamless integration with the existing State of Illinois user login system. DNA users can authenticate using their State of Illinois credentials while maintaining permissions and roles specifically designed by the DNA system.

FY2024 FST/TMU STATISTICS

DNA Reports Generated: 13,979

DNA Pageviews: 49,417

Help Desk Inquiries: 1,199

Data Requests Completed: 53

PROVIDER ANALYSIS UNIT (PAU) / RECIPIENT ANALYSIS UNIT (RAU)

In PAU, analysts with clinical expertise review provider claims and records for indications of fraud, waste, or abuse. The PAU analysts conduct in-depth reviews of billing records to determine if claims and services are appropriate. They investigate external and internal referrals by reviewing billing patterns, research aberrant billing practices, determine business inter-relationships, and collaborate in active investigations. Upon completion, the analysts present their findings to the Complaint Intake Unit as well as the Provider Review Committee (PRC). Analyst findings assist in deciding whether to continue a criminal and/or administrative investigation for issues such as fraud in billing practices, risk of harm to patients, substandard quality of care, and overprescribing. The committees may decide to issue a letter of concern or education to the provider; refer the provider within OIG to be audited, investigated or peer reviewed; or refer the provider to an external partner such as UPIC, DEA, IDFPR, or MFCU.

RAU is composed of analysts, with the oversight of medical consultants. RAU manages the Recipient Restriction Program (RRP) which identifies, detects, and prevents abuse of medical and pharmaceutical benefits by recipients enrolled in Medicaid. The program assigns at-risk recipients to one Primary Care Physician, Primary Care Clinic and/or Primary Care Pharmacy, ensuring the recipient receives coordination of all medical and pharmaceutical services (including referrals to specialists). Emergency and inpatient hospital services are not restricted. When recipients utilize various prescribing providers and pharmacies they are at a significant risk for adverse and potentially life-threatening situations. The RRP program, often referred to as a "lock-in" program, is designed to promote optimal recipient safety through care coordination. Recipients who may benefit from lock-ins are identified based on risk criteria programmed into OIG's selection algorithm and from external complaints received by OIG.

FY2024 PAU HIGHLIGHTS

Internal FWA Lead Generation: PAU data mining processes that began in FY2023 were formalized and streamlined in FY2024 through workflow development and presentation of results to the IDC. PAU's workflow uses DNA to investigate potential fraud, waste, and

abuse schemes to identify provider and procedure code outliers. Through data mining initiatives and workflow development, PAU staff optimized their collaborative efforts across HFS OIG and highlighted cases to open as internal referrals.

PAU Staff Testify at Criminal Trial: A notable case this fiscal year was the conviction and sentencing of Dr. William McMiller for defrauding the Illinois Medicaid program of more than $1.2 million. The case originated from PAU identifying aberrant billing patterns with the provider and referring to BOI for full investigation. In January 2024, PAU staff testified at McMiller's trial in support of the evidence that OIG provided.

FY2024 PAU STATISTICS

Complaint Intake Referrals Researched and Presented: 261

Case Consultations Provided: 73

Cases Reviewed and Presented for IDC: 48

Cases Completed: 15

Presented to Provider Review Committee: 8
- Education to provider: 1
- Referred to Peer Review: 1
- Referred to Audit: 1
- Referred to Investigations: 1
- No further action: 4

PAU closed no further action: 7

Case Open at End of FY2024: 1

FY2024 RAU HIGHLIGHT

Recipient Restriction Criteria Review: In FY2024, RAU staff reviewed recipient restriction logic and implementation in both fee for service and managed care. RAU collected the logic used by Illinois Medicaid's managed care organizations, as well the criteria used across all states in the nation. Though there are variables in enforcement, there are a few baseline criteria used nationwide. RAU's objectives included ensuring optimal application of consistent criteria which ensures access to proper medical care, while not over-burdening pharmacies and prescribers with unneeded restrictions. From this review, RAU intends to work with HFS's contracted MCOs to implement greater uniformity in the operation of these programs.

FY2024 RAU STATISTICS

Cases Started: 813

Cases Completed

MCO: 795

Recommended Restriction: 67

No Recommended Restriction: 728

FFS: 16

Restriction: 0

No restriction: 16

MCO Restrictions:[18] 1,589

Cost Avoidance[19]

MCO: $18,097,659

[18] MCO Restrictions is an unduplicated count of beneficiaries restricted by MCOs and includes a) any beneficiaries newly restricted during the fiscal year, and b) any beneficiaries whose restriction continued into the fiscal year.

[19] Cost Avoidance is an estimation of prevented expenditures based on past reimbursed services for the restricted beneficiaries. Restricted beneficiaries not receiving past reimbursed services are not included in the Cost Avoidance calculation.

Management, Research, and Analysis Section

MANAGEMENT, RESEARCH, AND ANALYSIS (MRA) SECTION

The Management, Research, and Analysis (MRA) Section facilitates professional development opportunities for all HFS OIG staff, including the creation and refreshing of in-house training sessions for new employees' onboarding and existing staff's continuing education. MRA staff also serve as enterprise-wide liaisons, ensuring effective communication and collaboration on HFS OIG work products and investigations initiatives, as well as with certain external partners, including HFS Bureau of Technology Services, HFS Provider Enrollment Services, Northern Illinois University Contractors, and the IMPACT Core project development team.

FY2024 MRA HIGHLIGHTS

Enterprise-Wide Liaison Activities: MRA led several projects to assist other HFS OIG bureaus' in their operations. First, MRA's portfolio expanded in FY2024 to include working with HFS OIG bureaus and sections to streamline workflows in the Case Administration and System Enquiry (CASE). For example, MRA worked with BMI Audits to build more efficient protocols within the database for clear reporting. MRA's model is assisting other units in streamlining their CASE reporting as well. Second, as OIG seeks to leverage studies and findings from the Healthcare Fraud Prevention Partnership (HFPP), MRA dedicated staff resources to the analysis of Illinois-specific HFPP studies. MRA is leading a team to determine if study results merit further OIG review and investigation, along with providing HFPP with feedback from HFS OIG's analysis. Finally, MRA staff began assisting BMI Audit staff with the processing of RAC claims, one of OIG's highest-volume programs.

Communications and Social Media Presence: In FY2024, HFS OIG established its presence on social media platforms LinkedIn, Instagram, and X (formerly Twitter). Social media posts include job opportunities, criminal case updates, and notable staff achievements. Through social media, HFS OIG provides updates on various aspects of its work, which increases public awareness of its mission to combat fraud, waste, and abuse in Illinois Medicaid and other government programs, and supports its prevention and deterrence efforts.

FY2024 TRAINING AND PROFESSIONAL DEVELOPMENT HIGHLIGHTS

- **Internal Staff Development:** MRA has developed several in-house training programs on essential software and proprietary databases to ensure all HFS OIG staff have the necessary foundational skills to further the office's mission. MRA collaborates actively in new employee onboarding activities to support staff being able to transition smoothly into their roles. This collaboration involves creating comprehensive training materials, conducting one-on-one sessions, and fostering a supportive environment for questions and feedback.

- **Regular Office Hours:** In FY2024, MRA began offering weekly office hours open to all HFS OIG staff, during which MRA assists with databases and programs, such as CASE, DNA, IMPACT and Microsoft Office products. These sessions give staff the opportunity to bring questions or issues and interact with various bureaus.
- **Facilitating Training Opportunities:** In FY2024, HFS OIG staff continued to have a plethora of opportunities to participate in learning sessions and training webinars offered by a variety of external partners. MRA facilitated sessions hosted by NHCAA, HFPP, and the National Association for Medicaid Program Integrity (NAMPI), by scheduling and broadcasting webinars and teleconferences for relevant staff, including auditors, investigators, nurses, attorneys, and data analytics staff.

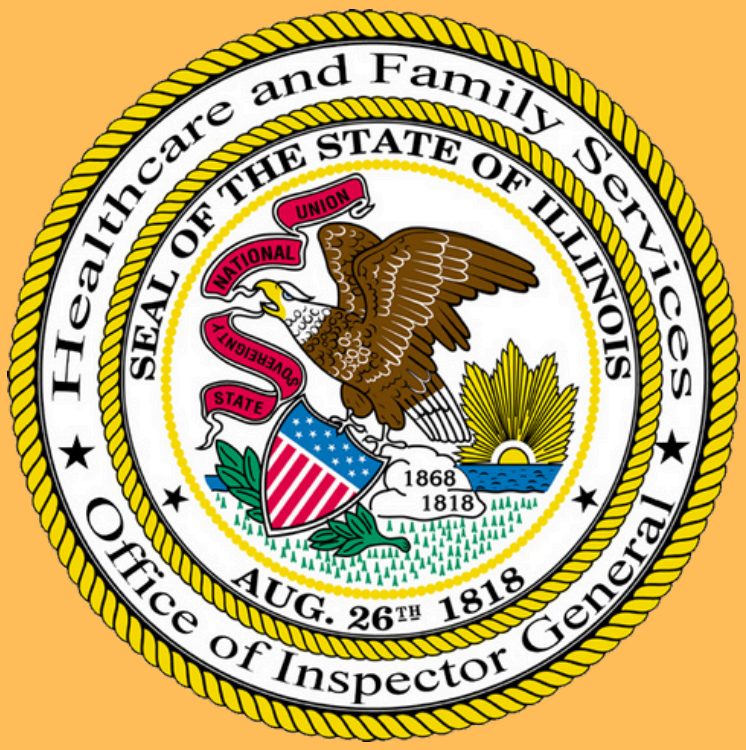
FY2024 MRA STATISTICS

Office-wide Trainings: 108

MRA-presented sessions: 54
IAMHP sessions shared: 18
HFS OIG Learning Series sessions: 10
Sessions shared from external sources:[20] 26

[20] These sources include organizations such as NHCAA, HFPP, NAMPI, AIG, MFCU, and MII.

Fiscal Management Unit



FISCAL MANAGEMENT UNIT

The Fiscal Management Unit handles budget, general collections, bad debt recovery, vendor invoicing and procurement matters for OIG. Fiscal Management maintains and updates OIG's operations budget and handles OIG's procurements and intergovernmental-agency agreements. It processes and tracks overpayments resulting from OIG audits of Medicaid providers, provider settlements and court-ordered restitutions. Fiscal Management establishes accounts receivable for all finalized overpayments and monitors these accounts until the debts are collected. If a debt is determined to be uncollectible, the uncollected debt case is forwarded to Bad Debt Recovery, which works with the Office of the Illinois Attorney General and the HFS Director's Office to enact and manage the State's process for writing off an uncollectible debt.

FY2024 FISCAL MANAGEMENT HIGHLIGHTS

Budget: OIG's FY2024 Operations budget was $6.9 million. General Revenue Fund expenditures constituted .88% of this amount while Part F – Public Aid Recoveries Trust Fund expenditures totaled 99.12%. The breakdown of the Operations budget follows, with percentages based on the total Operations budget.

64%	HMS, which is OIG's RAC vendor. HMS is paid on a contingency-fee basis.
23%	Other professional contracts, such as the OIG contract with Northern Illinois University, court reporting and audio transcription services, public records access and search services, GPSI contracts, and personal services contracts.
9%	1 statistical and 23 medical consultants.
4%	Employee travel, Conference fees and License Reimbursements.

Collections: Fiscal Management handles the recovery of overpayments established by a final audit determination, a final administrative determination, a provider settlement agreement, or a provider/client restitution agreement. Once an overpayment is finalized, Fiscal Management staff will establish an account receivable for the amount owed to HFS. If a provider fails to make a payment, Fiscal Management will send the provider an initial payment-reminder letter. If the provider does not comply with the initial reminder letter, Fiscal Management staff send the provider a fifteen-day demand letter. If the provider does not comply with the fifteen-day demand letter, the accounts are sent to Bad Debt Recovery and to OCIG for termination and barrment of the provider from the Medicaid program. In FY2024, Fiscal Management processed and maintained approximately 1,759 accounts receivables. FY2024 collections by audit type and provider type were as follows:

Audit Type	Provider Type
RAC audits – 63%	Hospital – 60%
Field audits – 16%	Long-term care – 32%
Desk audits – 11%	Physician – 3%
Self-disclosure audits – 6%	Transportation – 1%
UPIC Audits – 4%	Other – 4%

Demand Letters: In FY2024, the Fiscal Management Unit sent out fifteen-day demand letter for seven audits establishing $749,365 in overpayments. Four letters were sent to transportation companies, two letters to hospitals, and one to a long-term care facility. In response to these letters, Fiscal Management collected $11,323.

Bad Debt: When Fiscal Management has exhausted all attempts at collection and a debt is still outstanding, HFS OIG seeks to have the debt deemed uncollectible. Fiscal Management staff determine whether the case will go to an outside collection agency, to the HFS Director's office for write-off, or to the Office of the Illinois Attorney General (OAG) for write-off. This determination depends on various factors, including whether the providers or owners have assets and income to cover the debt owed. Bad debt cases finalized in FY2024 include the following:

Physician Overpayment of $80,306: OIG audited a physician and established a $80,306 overpayment. After the provider failed to pay and collections efforts were unsuccessful, the case was routed to OAG. After the OAG completed a Memorandum of Judgement against the provider in May of 2023, the provider agreed to enter a settlement agreement to pay back the debt from April 2024 through August 2027.

Transportation Overpayment of $282,222: HFS OIG conducted an audit of transportation provider, Pride Transportation, and identified an overpayment of $282,222. After the provider failed to agree to pay or appear at an administrative hearing, the HFS Director issued a Final Administrative Decision (FAD) which established the debt, terminated the provider from Medicaid, and barred its owners from participation. in the Medicaid program. Ultimately, Fiscal Management sent the debt to the OAG as uncollectible, and the OAG approved the write-off.

Transportation Overpayment for $95,327: HFS OIG audited transportation provider, Quick Vanns, and identified an overpayment of $95,327. The provider requested a hearing, but later withdrew the request after dissolving the company. A Final Administrative Decision established the provider's debt. After Fiscal Management's efforts to collect failed, the case was sent to the OAG as an uncollectible debt, and they approved the write-off. The provider was terminated from the Medicaid program and its owner was barred.

Procurement: During FY2024, the Fiscal Management Unit processed 39 contracts, 6 intergovernmental agency agreements, 4 data sharing agreements, and 1 joint operating agreement. These included 23 medical consultants contracts, 5 data and information contracts, a statistical consultant contract and a Recovery Audit Contractor. Fiscal

Management also helped oversee OIG's 13 intergovernmental agreements and 1 joint operating agreement with federal, state, and local partners.

FY2024 FISCAL MANAGEMENT STATISTICS

Collections

Account receivables: 584
New account receivables: 297
Outstanding account receivables: 287
Value of new account receivables established: $11,297,953
Collected account receivables: $8,790,289
Open account receivables: $58,190,595

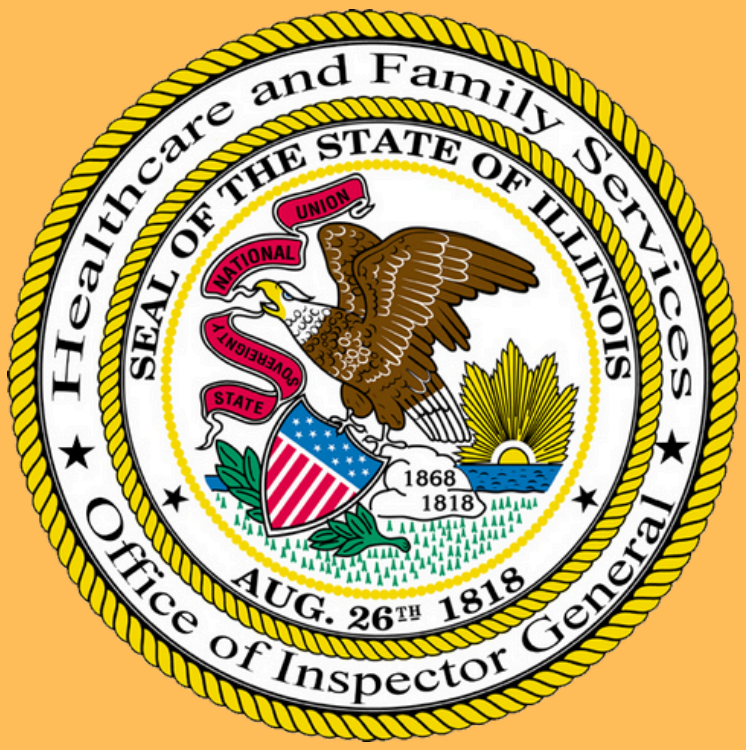
Bad Debt

Bad debt cases established: 3
Value of established bad debt cases: $151,149
Cases sent to collection agency: 14
Value of cases sent to collection agency: $732,400
Total bad debt cases written off: 24
Value of bad debt cases written off: $657,822

Procurement

Contracts: 39
Value of contracts: $3,724,307
Interagency agreements: 19
Value of interagency agreements: $700,000
Joint Operating Agreements: 1
Data Sharing Agreements: 4

Managed Care Program Integrity



MANAGED CARE PROGRAM INTEGRITY

Managed care program integrity has made significant strides in FY2024. With HFS OIG's creation of a dedicated Chief Managed Care Program Integrity Officer, improvement and expansion of the HFS OIG's MCO fraud reporting portal, and the coordination of program integrity efforts among the office's bureaus, HFS OIG has strengthened the foundations of its MCO oversight.

FY2024 MANAGED CARE PROGRAM INTEGRITY (PI) HIGHLIGHTS

New position: In FY2024, HFS OIG created a new position, Chief Managed Care Program Integrity Officer, dedicated specifically to prioritizing and streamlining Program Integrity efforts targeting the Illinois Medicaid Managed Care Program (MCP) and MCOs. The creation of this position centralized HFS OIG's managed care program integrity efforts. While the Chief Managed Care Program Integrity Coordinator position was filled in the second half of FY2024, quality improvements have already been made in prioritizing and proactively addressing program integrity efforts in the MCP and in collaborating with internal and external partners.

MCO Program Integrity Oversight Activities: HFS OIG utilizes an interdisciplinary approach to MCO program integrity oversight activities. Each of its bureaus played an active role, having worked both independently and collaboratively, in the Office's oversight endeavors during FY2024.

- BOI - Monitors and conducts investigations based on referrals submitted by the MCOs' Special Investigation Units (SIU) via the MCO fraud reporting portal.
- BMI - Refers cases to MCOs based on fee-for-service (FFS) fraud, waste, and abuse trends and schemes identified during audit conducted by the bureau and its UPIC.
- BFST - Spearheads data analysis of MCO paid claims and encounters, identifying outliers and anomalies in billing practices and innovating and improving HFS OIG's managed care PI data analysis capabilities.
- Fiscal Management Unit - Identifies providers who have received FFS overpayments for which the OIG will require recovery from an MCO.
- OCIG - As HFS OIG's legal department, OCIG has been critical to the Office's managed care program integrity efforts by taking administrative action to suspend, sanction, and terminate bad actors from the MCP and Medicaid generally.

MCO Fraud Portal: Launched in FY2023, the Portal serves not only as an interactive referral tool for SIUs to report incidents and investigations of fraud, waste, and abuse, it also functions as a tracking tool. In FY2024, HFS OIG began using the portal to cull data to analyze reporting rates and trends, overpayments identified and recovered by the SIUs, and to promote transparency in the OIG's managed care program integrity efforts.

Subcommittee Meetings: The OIG has continued to meet monthly with representatives of the MCOs' SIUs and MFCU to address MCO PI matters including, but not limited to, education and information sharing promoting collaboration among Medicaid PI partners. These meetings facilitate proactive identification of potential provider fraud and abuse issues and ensure coordination with law enforcement and the OIG on active fraud cases. New to FY2024, the OIG has shared monthly statistical reports with the SIUs documenting referrals made to the OIG as well as open and pending matters. The dissemination of these reports promotes transparency as well as accountability for both the SIUs and the OIG.

OIG and Bureau of Managed Care (BMC) coordinated efforts: During prior years, communication and collaboration with the BMC has been both limited and inconsistent. With the addition of HFS OIG's Chief of MCO PI Coordinator, HFS OIG and BMC have established monthly meetings and fostered more consistent communication and collaboration to address areas of mutual interest concerning MCO PI.

FY2024 MANAGED CARE PROGRAM INTEGRITY STATISTICS

MCO Fraud Portal

MCO Referrals: 661
HFS OIG Cases Opened Based on Referrals: 257
MCO Audits and Investigations Opened: 443
MCO Audits and Investigations Completed: 140
Overpayment Recovery Approval Requests: 570
Overpayment Recovery Approvals by HFS OIG:[21] 405
Overpayment Recovery Value Approved by HFS OIG: $23,041,619
Overpayments recovered:[22] $1,260,520

MCO Subcommittee Meetings

Subcommittee meetings held: 11
Leads HFS OIG provided to the subcommittee: 77

[21] Requests for overpayment recoveries may have been submitted to HFS OIG prior to the start of FY2024.
[22] Monies recovered may include recovery request made prior to the start of FY2024.

FY2024 ANNUAL REPORT

401 South Clinton Street
Chicago, IL 60607

2200 Churchill Road
Springfield, IL 62702

Medicaid Fraud Hotline:
1-844-ILFRAUD

www.illinois.gov/hfs/oig

Twitter: @HFSOIG
Instagram: @HFSOIG
LinkedIn: /company/hfsoig